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HEALTH INSURANCE AND RELATED PROVISIONS OF PUBLIC LAW 89-97, THE SOCIAL SECURITY AMENDMENTS OF 1965

PREPARED FOR THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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FOREWORD

This publication of the Special Committee on Aging is designed to serve as a ready reference for legislators, organizations and other individuals concerned with the health care provisions of the Social Security Amendments of 1965, Public Law 89–97. It contains the health insurance and related provisions of the new law with marginal annotations summarizing each section. To further assist the reader, the table of contents lists the page on which each section of the law may be found.

It is the hope of the members of the committee that this document will prove of value in understanding and implementing comprehensive and complex legislation.

GEORGE A. SMATHERS, *Chairman.*

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Health Insurance and Related Provisions of Public Law 89-97, the "Social Security Amendments of 1965."

(The annotations appearing in the margin of this print have been prepared solely for the convenience of the reader and do not have the force and effect of law.)

An Act

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary medical 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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1965".

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TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

SHORT TITLE

SEC. 100. This title may be cited as the "Health Insurance for the Aged Act".

Names title I of Act as "Health Insurance for the Aged Act."

PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Amends title II of Social Security Act by adding new section 226, "Entitlement to Hospital Insurance Benefits."

SEC. 101. Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Any person 65 and over entitled to OASI benefits or a qualified railroad retirement beneficiary will be entitled to hospital insurance benefits beginning July 1966.

"SEC. 226. (a) Every individual who—

"(1) has attained the age of 65, and

"(2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

"(b) For purposes of subsection (a)—

"(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or post-hospital home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later; and

Payment will be made for inpatient hospital services, post-hospital extended care services, post-hospital home health services and outpatient hospital diagnostic services only if furnished in United States (or, under 1814(f), outside U.S. in the case of certain emergency inpatient hospital services). Payment for post-hospital extended care services begins 1/1/67. Payment for post-hospital extended care services or home health services made only if individual is discharged from hospital after 6/30/66, or on or after first day of month of attainment of age 65, whichever is later.

"(2) an individual shall be deemed entitled to monthly insurance benefits under section 202, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

Individual is entitled to hospital insurance benefits for month in which he dies (not entitled to cash benefits for that month).

"(c) For purposes of this section, the term 'qualified railroad retirement beneficiary' means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the

"Qualified railroad retirement beneficiary" is defined under section 21 of Railroad Retirement Act, a new section shown on page 55 of this Act.

Railroad Retirement Board as the month in which he ceased to meet the requirements of section 21 of the Railroad Retirement Act of 1937.

"(d) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965."

Reference to section 103 of Act, page 48 (entitlement to hospital insurance benefits for certain uninsured individuals).

HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

Adds new title XVIII to Social Security Act.

SEC. 102. (a) The Social Security Act is amended by adding after title XVII the following new title:

"TITLE XVIII—HEALTH INSURANCE FOR THE AGED

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Title XVIII does not authorize any Federal officer or employee to exercise any supervision or control over practice of medicine or over operation or administration of medical facilities.

"SEC. 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

"FREE CHOICE BY PATIENT GUARANTEED

Beneficiary may choose any participating institution, agency or person which offers services to him.

"SEC. 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

"OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

Title XVIII does not preclude any State from providing (or any person from obtaining) protection against health costs.

"SEC. 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

"PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"DESCRIPTION OF PROGRAM

Hospital insurance program under part A of title XVIII provides basic protection against costs of hospital and related post-hospital services for people 65 or over entitled to retirement benefits under social security or railroad retirement systems.

"SEC. 1811. The insurance program for which entitlement is established by section 226 provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system.

"SCOPE OF BENEFITS

Benefits consist of entitlement for payment for: (1) inpatient hospital services for up to 90 days during spell of illness; (2) post-hospital extended care services for up to 100 days during spell of illness; (3) post-hospital home health services for up to 100 visits during a specified 1-year period; and (4) outpatient hospital diagnostic services.

"SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(1) inpatient hospital services for up to 90 days during any spell of illness;

"(2) post-hospital extended care services for up to 100 days during any spell of illness;

"(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and

"(4) outpatient hospital diagnostic services.

"(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

"(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 90 days during such spell;

"(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

"(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

Payment may not be made for more than (1) 90 days of inpatient hospital services during a spell of illness; (2) 100 days of post-hospital extended care services during a spell of illness; (3) lifetime maximum of 190 days of inpatient psychiatric hospital services.

"(c) If an individual is an inpatient of a psychiatric hospital or a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 90-day period immediately before such first day shall be included in determining the 90-day limit under subsection (b)(1) (but not in determining the 190-day limit under subsection (b)(3)).

If individual is in a psychiatric or in a TB hospital on 1st day of 1st month for which he is entitled to benefits under part A, the days in 90-day period preceding that 1st day will be counted toward 90-day maximum on hospital days covered in a spell of illness (but not in determining the 190-day lifetime maximum for inpatient psychiatric hospital services).

"(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.

Payment under part A for home health services limited to first 100 visits during the specified one year period following most recent hospital discharge.

"(e) For purposes of subsections (b), (c), and (d), inpatient hospital services, inpatient psychiatric hospital services, post-hospital extended care services, and post-hospital home health services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

Days of inpatient hospital services, inpatient psychiatric hospital services, post-hospital extended care services, and post-hospital home health services counted toward maximums only if payment is or would be made if individual requested it.

"(f) For definition of 'spell of illness', and for definitions of other terms used in this part, see section 1861.

"DEDUCTIBLES AND COINSURANCE

"SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to one-fourth of the

Amount payable by the program for inpatient hospital services furnished during any spell of illness will be reduced by amount of the inpatient hospital deductible, a term defined later in the section. If charges for such services are less than inpatient hospital deductible, amount payable will be reduced by amounts of charges imposed or customary charges, whichever are greater. Amount payable also reduced by coinsurance amount for each day of hospital care beyond 60 days during a spell of illness.

Coinsurance payment for each day of hospital care beyond the 60th is 1/4 of inpatient hospital deductible ($10 until 1969).

The deductible on outpatient hospital diagnostic services in a diagnostic study equals one-half of inpatient hospital deductible ($20 until 1969). Amount payable on outpatient hospital diagnostic services reduced by 20 percent coinsurance.

"Diagnostic study" defined as services furnished by same hospital during a 20-day period.

Payment will not be made for cost of first 3 pints of whole blood furnished an individual during a spell of illness.

Coinsurance payment for each day of post-hospital extended care services beyond 20th day is 1/8 of inpatient hospital deductible ($5 until 1969).

The inpatient hospital deductible will be $40 for any spell of illness and $20 for any diagnostic study beginning before 1969.

Secretary will, between July 1 and October 1 of 1968, and each year thereafter, determine inpatient hospital deductible to be applicable during following calendar year. This deductible will equal $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for preceding year, to (B) current average per diem rate for 1966. If amount so determined is not multiple of $4, it will be rounded to the nearest multiple of $4. The "current average per diem rate" is figured on the basis of the program's payments for inpatient hospital services.

inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell.

"(2) The amount payable for outpatient hospital diagnostic services furnished an individual during a diagnostic study shall be reduced by a deduction equal to the sum of (A) one-half of the inpatient hospital deductible which is applicable to spells of illness beginning in the same calendar year as such diagnostic study and (B) 20 per centum of the remainder of such amount. For purposes of the preceding sentence, a diagnostic study for any individual consists of the outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (not included in a previous diagnostic study) on which he is entitled to hospital insurance benefits under section 226 and on which outpatient hospital diagnostic services are furnished him.

"(3) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by an amount equal to the cost of the first three pints of whole blood furnished to him as part of such services during such spell of illness.

"(4) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

"(b)(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) shall be $40 in the case of any spell of illness or diagnostic study beginning before 1969.

"(2) The Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1866, to individuals who are entitled to hospital insurance benefits under section 226, plus the amount which would have been so paid but for subsection (a)(1) of this section.

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"Requirement of Requests and Certifications

"SEC. 1814. (a) Except as provided in subsection (d), payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

Payment for covered services made only if following 6 conditions are met:

"(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe;

(1) Written request (signed by beneficiary or by another person when it is impractical for him to do so) is filed, and

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(2) A physician certifies (and recertifies where services furnished over period of time, but before 21st day of inpatient hospital services) that:

"(A) in the case of inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services), such services are or were required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is or was medically required and such services are or were necessary for such purpose;

(A) hospital services (other than inpatient psychiatric and inpatient T.B. hospital services) are required on an inpatient basis for medical treatment or inpatient diagnostic study;

"(B) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) psychiatric hospital services are required on an inpatient basis for psychiatric treatment, and treatment can be expected to improve condition, or inpatient diagnostic study is medically required;

"(C) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) T.B. hospital services are required on an inpatient basis for treatment of T.B., and treatment can be expected to improve condition or render it noncommunicable;

"(D) in the case of post-hospital extended care services, such services are or were required to be given on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) prior to transfer to the extended care facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) post-hospital extended care services are required on an inpatient basis because beneficiary needed continuous skilled nursing care for condition for which hospitalized prior to transfer, or which arose while receiving such care;

(E) home health services are required because beneficiary was confined to his home (except for certain outpatient services) and needed intermittent skilled nursing care, or physical or speech therapy for any condition for which he was receiving hospital or extended care services, and that services were performed under plan established and periodically reviewed by a physician; or

(F) outpatient hospital diagnostic services were required for diagnostic study.

3. In case of psychiatric hospital services, services are those which hospital records show were furnished to individual during periods when he was receiving intensive treatment, services necessary for diagnostic study, or equivalent services.

4. In case of inpatient T.B. hospital services, services are those which hospital's records show were furnished while individual was receiving treatment which could be expected to improve his condition or render it noncommunicable.

5. In case of hospital services furnished after 20th day of continuous stay or for extended care furnished after prescribed period of time, hospital or facility makes timely utilization review of long-stay cases.

6. Utilization review finding is not made that inpatient hospital or extended care services are not medically necessary, except that payment may be made until 4th day after day notice of such finding is received by hospital or facility..

To extent provided by regulations, certification requirements will be satisfied where at date later than day certifications are required under (2) above, physician makes required certification, if it is accompanied by such evidence as may be required.

"(E) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

"(F) in the case of outpatient hospital diagnostic services, such services are or were required for diagnostic study;

"(3) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

"(4) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

"(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or extended care facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

"(6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4)) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), (E), or (F) of paragraph (2)

(whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

"Reasonable Cost of Services

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v).

Provides that amount to be paid any provider of services under part A will be, subject to the deductible and coinsurance provisions, the reasonable cost of services (as determined under section 1861(v)). See p. 37.

"No Payments to Federal Providers of Services

"(c) No payment may be made under this part (except under subsection (d)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

No payment can be made to Federal provider, except for emergency services, unless it serves as a community institution. Payment cannot be made to provider for services it is obligated to render at public expense under Federal law or contract.

"Payments for Emergency Hospital Services

"(d) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

Payment may be made for emergency inpatient hospital services or emergency outpatient hospital diagnostic services even if hospital is not regular participator in program if hospital agrees not to charge beneficiary for covered services.

"Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

"(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

If hospital acted reasonably in assuming individual was entitled to payment for hospital services, hospital can get payment for services furnished even if individual is not entitled, provided the nonentitlement results from limits on number of covered days. No payment made under this provision if hospital obtains and does not refund payment from individual. Payment may not be made under this provision for services furnished after the 6th elapsed day after the day of admission (not counting Saturday, Sunday, or a legal holiday as an elapsed day) or after notice of lack of entitlement, whichever is first.

Payment may be made for emergency inpatient hospital services furnished outside U.S. if (1) the person is in U.S. at time emergency occurred and (2) hospital was closer or more accessible than nearest hospital in U.S. adequately equipped to treat the individual.

"Payment for Certain Emergency Hospital Services Furnished Outside the United States

"(f) The authority contained in subsection (d) shall be applicable to emergency inpatient hospital services furnished an individual by a hospital located outside the United States if—

"(1) such individual was physically present in a place within the United States at the time the emergency which necessitated such inpatient hospital services occurred; and

"(2) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

Secretary will determine amounts to be paid providers under part A, and they will be paid not less often than monthly. Provider must furnish information requested by Secretary in order to determine amounts due.

"PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1815. The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Secretary may enter into agreement with organizations nominated by providers under which they would determine amount of payments and make payments to providers.

"USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

Agreement may include provision for organization to (1) provide consultative services to enable providers to qualify to participate; (2) serve as centers for communicating with providers; (3) make audits of provider records; (4) perform related functions.

"(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of this part, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part.

Secretary will not enter into agreement with nominated organizations unless to do so is consistent with effective and efficient administration, and unless agency or organization is willing to assist providers in application of safeguards against unnecessary utilization, and unless agency or organization agrees to furnish Secretary necessary information it acquires.

"(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement.

Agreement may provide for advance of funds to agency or organization for making payments to providers and will provide for payment of administrative costs.

"(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

Provider may withdraw its nomination to receive payments through organization. Any provider may elect to receive payments from Secretary or from any organization which has agreement, if Secretary and organization agree.

"(e) An agreement with the Secretary under this section may be terminated—

"(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

Agreement may be terminated by agency or organization at such time and upon such notice as may be provided in regulations.

"(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

Secretary may terminate agreement, after opportunity for hearing, only if (1) organization fails to carry out agreement or (2) continued delegation of functions to organization disadvantageous or inconsistent with efficient administration.

"(f) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Agreement may require employees of organization who handle funds to give surety bond in amount determined by the Secretary.

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No employee of organization with agreement who is responsible for certifying or disbursing payments is liable, in absence of gross neglect or intent to defraud, for improper payments; neither is such organization liable.

"(g)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

Creates Federal Hospital Insurance Trust Fund.

"FEDERAL HOSPITAL INSURANCE TRUST FUND

"SEC. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

Trust Fund consists of amounts deposited in or appropriated to it.

Appropriation to Trust Fund from Treasury for fiscal year ending 6/30/66 and thereafter equals 100 percent of:
(1) taxes (imposed by sections 3101(b) and 3111(b) of Internal Revenue Code) on wages; and (2) taxes (imposed by section 1401(b) of Code) on self-employment income. Taxes effective 1/1/66. These amounts will be transferred periodically on the basis of estimates, and adjustments will be made to extent estimates are higher or lower than actual taxes.

"(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

Creates Board of Trustees of the Trust Fund who will meet at least once each calendar year.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the

'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

"(1) Hold the Trust Fund;

"(2) Report to the Congress not later than the first day of March of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

"(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

Board's duties are to (1) hold Fund, (2) report to Congress by March 1 each year on operation and status of Fund, (3) report to Congress whenever Board thinks amount of Fund is unduly small, and (4) review and recommend changes (including legislative changes) in policies followed in managing Fund.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

Managing Trustee will invest portion of Fund not required to meet current withdrawals. Investments made only in interest-bearing obligations of U.S. or in obligations guaranteed as to principal and interest by U.S. Other obligations of U.S. or guaranteed by U.S. may be purchased by Managing Trustee only when he determines it is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

Obligations acquired by Trust Fund may be sold at market price and public-debt obligations may be redeemed at par plus interest.

Interest and proceeds from sale of obligations credited to and form part of Trust Fund.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

Managing Trustee to pay periodically from Trust Fund into Treasury the amount estimated as taxes on wages which are subject to refund where workers paid taxes on over $6600 because he had more than 1 employer. These repayments will be carried to surplus fund of Treasury.

"(f)(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary of Health, Education, and Welfare shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

"(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

Transfers at least once each fiscal year from OASI Trust Fund, DI Trust Fund, and Railroad Retirement Account to Hospital Insurance Trust Fund hospital insurance overpayments recovered by adjusting cash social security or railroad retirement benefits.

"(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

Managing Trustee will pay from the Trust Fund amounts necessary to make benefit payments and to pay administrative expenses.

"(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

Establishes voluntary medical insurance program for individuals 65 or over to be financed from premium payments by enrollees and by contributions from general tax funds of Federal Government.

"PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

"ESTABLISHMENT OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR THE AGED

"SEC. 1831. There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for individuals 65 years of age or over who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

"SCOPE OF BENEFITS

"SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

"(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in paragraph (2)(B); and

"(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(A) home health services for up to 100 visits during a calendar year; and

"(B) medical and other health services (other than physicians' services unless furnished by a resident or intern of a hospital) furnished by a provider of services or by others under arrangements with them made by a provider of services.

"(b) For definitions of 'spell of illness', 'medical and other health services', and other terms used in this part, see section 1861.

Convenient reference for distinguishing between services for which payment will be made on basis of charges and those for which payment will be made on basis of costs. Most benefits under paragraph (1) are paid on basis of reasonable charges, and paragraph (2) is the exception involving services furnished by hospitals or other providers (or by others under arrangements with them), which are paid for on basis of reasonable costs.

"PAYMENT OF BENEFITS

"SEC. 1833. (a) Subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

"(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b); and

"(2) in the case of services described in section 1832(a)(2)—80 percent of the reasonable cost of the services (as determined under section 1861(v)).

Subject to the individual meeting an annual deductible of $50, payment made for 80 percent of reasonable charges for physicians' services and certain medical and other health services, except that prepayment organizations which furnish services (not just insure costs) have option to have payment made on basis of reasonable cost instead of reasonable charges.

Payment made for 80 percent of reasonable cost of home health, and specified medical and other health services.

"(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $50; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year (or regarded under clause (2) as incurred in such preceding year with respect to services furnished in such last three months) and applied toward such individual's deductible under this section for such preceding year, and (2) the amount of any deduction imposed under section 1813(a)(2)(A) with

Beneficiary subject to $50 deductible annually before any payment is made by program under part B; however, (1) amount of any expenses which beneficiary incurred in last 3 months of preceding calendar year and which applied to that year's deductible would be applied to current year's deductible; and (2) the amount of deduction imposed under part A with respect to outpatient hospital diagnostic services will be regarded as an incurred expense under part B.

Notwithstanding any other provisions of part B, the smaller of $312.50 or 62 1/2 percent as a special maximum on covered expenses incurred in calendar year for treatment of mental, psychoneurotic, and personality disorders when not an inpatient of hospital. When 80 percent coinsurance applied to these maximums, the limit on dollar amount that can be paid for such expenses is $250 or 50 percent of the charges, whichever is less.

Payment may not be made under part B for services furnished an individual if individual entitled to have payment made for those services under part A (or would be entitled except for deductibles other than outpatient hospital diagnostic deductibles).

'No payment made under part B unless information necessary to determine the amounts of such payments has been furnished.

Payment may not be made for home health services furnished an individual after such services have been furnished to him for 100 visits during calendar year.

For purposes of limits on duration for which payment may be made, home health services shall be taken into account only if payment is made or would be made if the request and certification requirements described below were met.

Payment for covered services may be made only to eligible provider of services and only if:

(1) written request is filed by individual (or others designated when impracticable for individual to sign);

(2) physician certifies (and recertifies where services furnished over a period of time as often as may be provided in regulations) that:

(A) in the case of home health services, services required because individual is home-bound and needs intermittent skilled nursing care or physical or speech therapy and that the services are furnished under care of a physician under a physician's plan; and

respect to outpatient hospital diagnostic services furnished in any calendar year shall be regarded as an incurred expense under this part for such year.

"(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

"(1) $312.50, or

"(2) 62½ percent of such expenses.

"(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813 other than subsection (a)(2)(A) thereof) to have payment made with respect to such services under part A.

"(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

"LIMITATION ON HOME HEALTH SERVICES

"SEC. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

"(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.

"PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

"SEC. 1835. (a) Payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

"(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulations prescribe; and

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

"(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy,

(ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

"(B) in the case of medical and other health services, such services are or were medically required.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

"(b) No payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

"ELIGIBLE INDIVIDUALS

"SEC. 1836. Every individual who—

"(1) has attained the age of 65, and

"(2) (A) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, or (B) is entitled to hospital insurance benefits under part A,

is eligible to enroll in the insurance program established by this part.

"ENROLLMENT PERIODS

"SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

"(b) (1) No individual may enroll for the first time under this part more than 3 years after the close of the first enrollment period during which he could have enrolled under this part.

"(2) An individual whose enrollment under this part has terminated may not enroll for the second time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the effective date of such termination. No individual may enroll under this part more than twice.

"(c) In the case of individuals who first satisfy paragraphs (1) and (2) of section 1836 before January 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on March 31, 1966. For purposes of this subsection and subsection (d), an individual who satisfies paragraph (2) of section 1836 solely by reason of subparagraph (B) thereof shall be treated as satisfying such paragraph (2) on the first day on which he is (or on filing application would be) entitled to hospital insurance benefits under part A.

"(d) In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 on or after January 1, 1966, his initial enroll-

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

Delayed certifications and recertifications may be accepted if accompanied by required evidence.

No payment may be made to a Federal provider of services unless it is determined to be providing services to the public generally as a community institution or agency. No payment may be made to any provider for any item or service it is required to render at public expense under law or contract with U.S.

Individual who is 65 or over and is (A) a resident of the U.S. and either (1) citizen or (2) alien lawfully admitted for permanent residence and has resided in U.S. continously for 5 years preceding month of application, or (B) entitled to benefits under part A, is eligible to enroll in the insurance program established by part B.

Individual may enroll in part B insurance program only in manner and form prescribed in regulations and only during enrollment period described in this section.

No individual may enroll for first time under part B more than 3 years after close of the first enrollment period during which he could have enrolled.

An individual whose enrollment has terminated may not enroll for second time unless he does so in general enrollment period which begins within 3 years after the effective date of termination. (No individual may enroll under part B more than twice.)

For individuals who meet the eligibility requirements before 1/1/66 (are 65 before 1/1/66), initial general enrollment period begins 9/1/65 and ends 3/31/66. For the purposes of deciding when an individual meets the eligibility requirements, individuals who meet the eligibility requirement solely by reason of his entitlement to benefits under part A will be considered as satisfying the requirement on the first day he is (or on filing application would be) entitled to benefits under part A.

For an individual who meets eligibility requirements on or after 1/1/66, initial enrollment period begins on first day of third month before month in which he meets eligibility requirements and ends 7 months later.

ment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later.

"(e) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on October 1 and ending on December 31 of each odd-numbered year beginning with 1967.

There will be a general enrollment period from October 1 to December 31 of each odd-numbered year beginning with 1967.

"COVERAGE PERIOD

"SEC. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his 'coverage period') shall begin on whichever of the following is the latest:

"(1) July 1, 1966; or

"(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraphs (1) and (2) of section 1836, the first day of such month, or

"(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraphs, the first day of the month following the month in which he so enrolls, or

"(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraphs, the first day of the second month following the month in which he so enrolls, or

"(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraphs, the first day of the third month following the month in which he so enrolls, or

"(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls.

"(b) An individual's coverage period shall continue until his enrollment has been terminated—

"(1) by the filing of notice, during a general enrollment period described in section 1837(e), that the individual no longer wishes to participate in the insurance program established by this part, or

"(2) for nonpayment of premiums.

"Coverage period" is defined as period during which individual is entitled to benefits under medical insurance program. An individual's coverage period: (1) cannot begin before July 1, 1966; (2) in the case of an individual who enrolls during the 7-month enrollment period for an individual meeting the eligibility requirements after 12/31/65, his coverage period begins (a) the month he becomes eligible, if he enrolls before that month; or (b) the month following the month he is eligible, if he enrolls in the month he becomes eligible; or (c) the second month following the month he enrolls, if he enrolls in the month following the month he becomes eligible; or (d) the third month following the month he enrolls, if he enrolls more than one month following the month he becomes eligible; or (3) in the case of an individual who enrolls in a general enrollment period, the July 1 following his enrollment.

Coverage period shall continue until individual's enrollment has been terminated (1) by filing of notice, during a general enrollment period, that he no longer wishes to participate, or (2) by nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of December 31 of the year in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period (not in excess of 90 days) in which overdue premiums may be paid and coverage continued.

"(c) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

Payment may be made under part B only for expenses incurred by an individual during his coverage period.

"AMOUNTS OF PREMIUMS

"SEC. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be $3.

Monthly premium for each individual enrolled under part B for each month before 1968 is $3.00.

"(b)(1) The monthly premium of each individual enrolled under this part for each month after 1967 shall be the amount determined under paragraph (2).

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

Between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, the premium will be determined for months occurring in the 2 succeeding calendar years. The premium will be the amount estimated to be necessary so that agregate premiums will equal one-half benefits and administrative costs payable from Supplementary Medical Insurance Trust Fund for the 2 succeeding years. In estimating aggregate benefits payable for any period, allowance will be included for contingency margin.

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

In the case of an individual who enrolls after his initial enrollment period, his monthly premium will be increased by 10 percent for each full 12 months in which he could have been but was not enrolled.

"(d) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

Any monthly premium which is not a multiple of 10 cents will be rounded to the nearest multiple of 10 cents.

"PAYMENT OF PREMIUMS

"SEC. 1840. (a) (1) In the case of an individual who is entitled to monthly benefits under section 202, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

Monthly premiums of social security beneficiaries collected by deducting premiums from social security benefits.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

Secretary of Treasury will periodically transfer from OASI and DI Trust Funds to Supplementary Medical Insurance Trust Fund amounts deducted for premiums.

"(b) (1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

In the case of an individual entitled to annuity or pension under Railroad Retirement Act, monthly premium is to be deducted from that annuity or pension.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount

Secretary of the Treasury will periodically transfer from Railroad Retirement Account to Supplementary Medical Insurance Trust Fund total amounts deducted for premiums.

In the case of an individual entitled to both social security and railroad retirement benefits, deduction for premiums will be made from social security benefits, except in cases in which the individual was entitled to railroad retirement benefits before he was entitled to social security benefits.

An individual who estimates that amount of social security or railroad retirement benefits available for deduction for any period will be less than amount of premiums for that period may make an additional cash payment.

An individual receiving an annuity under Federal civil service retirement or another retirement system administered by CSC and who is not entitled to monthly SS or RR benefits may have premiums for medical insurance deducted from his annuity.

Secretary of the Treasury will periodically transfer from CS Retirement and Disability fund to Supplementary Medical Insurance Trust Fund the amounts deducted by Civil Service.

In the case of an individual who enrolls in part B but who is neither a social security nor a railroad retirement beneficiary nor a Civil Service annuitant, premiums are to be paid in a manner prescribed by regulations.

Premiums paid deposited in the Federal Supplementary Medical Insurance Trust Fund.

deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"(c) In the case of an individual who is entitled both to monthly benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.

"(d) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

"(e)(1) In the case of an individual receiving an annuity under the Civil Service Retirement Act, or other Act administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

"(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other Act administered by the Civil Service Commission, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"(f) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (d) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

"(g) Amounts paid to the Secretary under subsection (d) or (f) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

"(h) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

Premiums payable for period beginning with first month of coverage period and ending with the month in which individual dies or his coverage period ends, whichever is earlier.

"FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Creates Federal Supplementary Medical Insurance Trust Fund.

"SEC. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Supplementary Medical Insurance Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

Creates Board of Trustees of the Trust Fund who will meet at least once each calendar year.

"(1) Hold the Trust Fund;

"(2) Report to the Congress not later than the first day of March of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

"(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

Board's duties are to (1) hold the Fund, (2) report to Congress by March 1 each year on operation and status of Fund, (3) report to Congress whenever Board thinks amount of Fund is unduly small, and (4) review and recommend changes (including legislative changes) in policies followed in managing the Fund.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have matu-

Managing Trustee will invest portion of Trust Fund not required to meet current withdrawals. Investments made only in interest-bearing obligations of U.S. or in obligations guaranteed as to principal and interest by U.S. Other obligations of U.S. or guaranteed by U.S. may be purchased by Managing Trustee only when he determines it is in the public interest.

rities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

Obligations acquired by Trust Fund may be sold at market price and public-debt obligations may be deemed at par plus interest.

"(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

Interest on and proceeds from sale of obligations credited to and form part of Trust Fund.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

Transfers will be made at least once each fiscal year to Supplementary Medical Insurance Trust Fund from OASI Trust Fund, DI Trust Fund and Railroad Retirement Account of medical insurance overpayments recovered by adjusting cash social security or railroad retirement benefits.

"(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

Managing Trustee will pay from the Trust Fund amounts necessary to make benefit payments and to pay administrative expenses.

"(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

Managing Trustee will pay from the Trust Fund amounts necessary to pay cost incurred by the CSC in making deductions for Civil Service Retirement annuitants.

"(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Civil Service Commission in making deductions pursuant to section 1840(e). During each fiscal year, or after the close of such fiscal year, the Civil Service Commission shall certify to the Secretary the amount of the costs it incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

"USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

The Secretary may enter into contracts with carriers, including organizations which have agreements to act as fiscal intermediaries under part A (and must enter into such contracts to the extent possible with respect to payment for physicians' services), which will undertake to perform, or to secure performance by other organizations, of the following part B functions:

"SEC. 1842. (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the

benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services, the Secretary shall to the extent possible enter into such contracts:

"(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

"(B) receive, disburse, and account for funds in making such payments; and

"(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

"(2)(A) determine compliance with the requirements of section 1861(k) as to utilization review; and

"(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

"(3) serve as a channel of communication of information relating to the administration of this part; and

"(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

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

"(2) No such contract shall be entered into with any carrier unless the Secretary finds that such 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.

"(3) Each such contract shall provide that the carrier—

"(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

"(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, (i) such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and (ii) such payment 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 is the full charge for the service;

"(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an oppor-

(A) make determinations of rates and amounts of payments to be made to providers of services and other persons on reasonable cost or reasonable charge basis, whichever is applicable;

(B) receive, disburse, and account for funds in making such payments; and

(C) audit records of providers of services to assure that proper payments are made.

Also, carriers will:

(A) determine compliance with utilization review requirement;

(B) assist in development of utilization review procedures; make studies of effectiveness of such procedures; assist in application of safeguards against unnecessary utilization of services; assist in arranging, where necessary, the establishment of groups outside hospitals to make reviews of utilization.

Carriers will also: serve as channel of communication of information relating to administration of program and assist in discharging other administrative duties.

Contracts with carriers may be entered into without competitive bidding.

The Secretary not to contract with carrier unless carrier will perform its duties efficiently and effectively and meets requirements relating to financial responsibility, legal authority and other matters as he finds pertinent.

Each contract must provide that the carrier will:

(A) take action to assure that where payment is on a cost basis, the cost is reasonable cost;

(B) take action to assure that where payment is on a charge basis, charge is reasonable and not higher than charge applicable for comparable service to policy-holders of carrier and such payment is on the basis of either a receipted bill or an assignment under which the reasonable charge is full charge for services;

(C) establish and maintain procedures under which an individual enrolled

under the medical insurance plan will be entitled to fair hearing by carrier when requests for payment are denied, not acted upon with reasonable promptness, or amount of payment is in controversy;
(D) furnish such timely information and reports as may be necessary;
(E) maintain and afford access to whatever records necessary for verification of required information and reports and otherwise to carry out the purposes of the medical insurance plan.

Each contract will also contain other necessary terms and conditions. In determining reasonable charges, carriers will consider physician's customary charges for similar services and prevailing charges in locality.

Each contract must be for term of at least 1 year and may be automatically renewable unless either party provides notice of intent to terminate at end of current term. Secretary may terminate at any time (after reasonable notice and opportunity for hearing) if he finds that carrier has failed substantially to carry out contract or is carrying it out in manner inconsistent with efficient and effective administration.

Contract will provide for advances of funds to the carrier for making benefit payments and will provide for payment of administrative costs.

Contract may require carrier or its officers and employees certifying payments or disbursing funds to give surety bond in appropriate amount.

No individual designated pursuant to a contract as certifying officer will, in absence of gross negligence or intent to defraud, be liable for payments incorrectly certified by him.

No individual designated as disbursing officer will, in absence of gross negligence or intent to defraud, be liable for any payment if it was based on a voucher signed by a certifying officer.

Employing agency of certifying or disbursing officer not liable to U.S. when such officer is excused.

For purposes of part B, term "carrier" means:

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership contracts or similar group

tunity for a fair hearing by the carrier when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

"(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

"(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

"(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

"(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

"(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

"(f) For purposes of this part, the term 'carrier' means—

"(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar

group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

"(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

arrangements in consideration of premiums or other periodic charges, including an employee organization health benefits plan; and

(2) with respect to providers of services only, any agency or organization (not described above) with which an agreement is in effect for such agency or organization to act as a fiscal intermediary under part A.

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

"SEC. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1968, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

The Secretary will, at request of a State made before 1/1/68, enter into agreement with State to provide coverage under part B for eligible individuals in either of the two coverage groups specified below:

(1) aged recipients of money payments under plan of such State approved under OAA, MAA or the program which combines categories of Act; or

(2) aged recipients of money payments under all State assistance plans under social security. Neither group may include any individual entitled to monthly OASI or railroad retirement benefits.

"(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

"(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

"(2) individuals receiving money payments under all of the plans of such State approved under titles I, IV, X, XIV, and XVI;

except that there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

"(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date and before January 1, 1968; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter before January 1968.

Coverage under an agreement with a State may be provided only for individual who is eligible on date agreement is entered into or who becomes eligible in period after date of agreement and before 1/1/68.

"(d) In the case of any individual enrolled pursuant to this section—

"(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (c) thereof);

"(2) his coverage period shall begin on whichever of the following is the latest:

"(A) July 1, 1966;

"(B) the first day of the third month following the month in which the State agreement is entered into;

"(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

"(D) such date (not later than January 1, 1968) as may be specified in the agreement; and

"(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

"(A) the month in which he is determined by the State agency to have become ineligible for money payments of a kind specified in the agreement, or

In the case of individual enrolled in program under part B pursuant to an agreement between a State and the Secretary:

(1) premium to be paid by State will be the same as for other enrollees (except the 10% increase in premium for late enrollment does not apply);

(2) his coverage period will begin on July 1, 1966; on first day of third month following month the State agreement is entered into; on first day of first month in which he is both an eligible individual and a member of the coverage group; a date not later than 1/1/68 as may be specified in the agreement; whichever is latest;

(3) his coverage period will end on either last day of month in which he is no longer eligible for cash aid or last day of the month before month he becomes entitled to monthly OASI or railroad retirement benefits, whichever occurs first.

"(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

Any individual whose coverage period attributable to a State agreement is terminated will be deemed to have enrolled in initial enrollment period.

"(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c).

The term "carrier" also includes, with respect to individuals receiving money payments, and if the agreement so provides, State agency specified in agreement which administers State assistance plan. Agreement must contain provisions to facilitate handling deductions and coinsurance and otherwise lead to economy and efficiency of operations.

"(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, IV, X, XIV, or XVI, if the agreement entered into under this section so provides, the term 'carrier' as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, IV, X, XIV, and XVI.

"APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

Authorizes appropriations from Treasury equal to total premiums payable by individuals who have enrolled under part B.

"SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund, a Government contribution equal to the aggregate premiums payable under this part.

Authorizes appropriation from Treasury to remain available through 1967 for repayable advances to Trust Fund of $18 multiplied by the estimated number of individuals who could be covered in July 1966 by the program under part B in order to assure prompt payment of benefits and administrative expenses and to provide contingency reserve during early months of program.

"(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1967 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

"PART C—MISCELLANEOUS PROVISIONS

"DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

"SEC. 1861. For purposes of this title—

"Spell of Illness

Defines "spell of illness" as beginning with first day (not in a previous spell of illness) on which individual entitled to benefits under part A is furnished inpatient hospital or extended care services,

"(a) The term 'spell of illness' with respect to any individual means a period of consecutive days—

"(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

"(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility.

and ending with last day of first 60-consecutive-day period during which he was neither an inpatient in a hospital nor an extended care facility.

"Inpatient Hospital Services

"(b) The term 'inpatient hospital services' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board;

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

"(4) medical or surgical services provided by a physician, resident, or intern; and

"(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association.

Defines "inpatient hospital services" as services ordinarily furnished by hospital for care and treatment of its inpatients. Includes diagnostic and therapeutic services furnished under arrangements made by hospital with others who provide the services. Excludes private-duty services of nurses and other attendants, and medical and surgical services of physicians, except services rendered by intern or resident-in-training under teaching program approved by American Medical Association, American Osteopathic Association, or Council on Dental Education of American Dental Association.

"Inpatient Psychiatric Hospital Services

"(c) The term 'inpatient psychiatric hospital services' means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Defines "inpatient psychiatric hospital services" as services furnished to inpatient of psychiatric hospital.

"Inpatient Tuberculosis Hospital Services

"(d) The term 'inpatient tuberculosis hospital services' means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Defines "inpatient tuberculosis hospital services" as services furnished to inpatient of tuberculosis hospital.

"Hospital

"(e) The term 'hospital' (except for purposes of section 1814(d), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) maintains clinical records on all patients;

Defines "hospital" as institution which: (1) is primarily engaged in providing diagnostic and therapeutic or rehabilitation services; (2) maintains clinical records;

(3) has bylaws for medical staff;
(4) requires every patient to be under care of physician;
(5) provides 24-hour nursing services under supervision of RN and has licensed practical nurse or RN on duty at all times;
(6) has utilization review plan in effect;
(7) is licensed (or meets standards for licensing) pursuant to State or local law; and
(8) meets other requirements necessary for health and safety except that such requirements may not be higher than those prescribed by Joint Commission on Accreditation of Hospitals (except in certain cases where higher requirements result from State initiative--see page 40).

"(3) has bylaws in effect with respect to its staff of physicians;
"(4) has a requirement that every patient must be under the care of a physician;
"(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
"(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);
"(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and
"(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863).

For purposes of determining how long an individual is out of a hospital to establish end of spell of illness, institution meeting first element of definition above is a "hospital." In determining whether emergency inpatient hospital services are covered, institution considered "hospital" if it meets elements (1), (2), (3), (4), (5), and (7) above.

The term "hospital" does not (except for purposes of determining when spell of illness ends) include any institution which is primarily for the care and treatment of mental diseases or TB, unless it is TB or psychiatric hospital as subsequently defined.

The term "hospital" also includes Christian Science sanatorium (but payment to such institution made only to extent and under conditions provided in regulations) if operated, or listed and certified by First Church of Christ, Scientist, Boston, Mass.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) (including determination of whether an individual received inpatient hospital services for purposes of such section), and subsections (i) and (n) of this section, such term includes any institution which meets the requirements of paragraphs (1), (2), (3), (4), (5), and (7) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term 'hospital' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

Certain requirements of this subsection may be deemed met if hospital is accredited.

Defines "psychiatric hospital" as institution which:
(1) is primarily engaged in providing psychiatric services for diagnosis and treatment of mentally ill persons;
(2) satisfies requirements (3) through (8) in definition of "hospitals;"
(3) maintains records which enable determination of degree and intensity of treatment provided;

"Psychiatric Hospital

"(f) The term 'psychiatric hospital' means an institution which—
"(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;
"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);
"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'psychiatric hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

(4) meets staffing requirements commensurate with active program of treatment; and
(5) is accredited by Joint Commission on Accreditation of Hospitals.

If an institution meets requirements (1) and (2) above and distinct part of it meets (3) and (4), and if institution is accredited by JCAH or if distinct part meets requirements equivalent to accreditation, distinct part considered psychiatric hospital.

"Tuberculosis Hospital

"(g) The term 'tuberculosis hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'tuberculosis hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Defines "TB hospital" as institution which: (1) is primarily engaged in providing medical services for diagnosis and treatment of TB; (2) satisfies requirements (3) through (8) of definition of "hospital;" (3) maintains records which enable determination of degree and intensity of treatment provided; (4) meets staffing requirements commensurate with active program of treatment; and (5) is accredited by Joint Commission on Accreditation of Hospitals.

Distinct part of an institution considered "TB hospital," if institution meets requirements (1) and (2) above and distinct part meets requirements (3) and (4), and if institution is accredited by JCAH or if distinct part meets requirements equivalent to accreditation.

"Extended Care Services

"(h) The term 'extended care services' means the following items and services furnished to an inpatient of an extended care facility and (except as provided in paragraphs (3) and (6)) by such extended care facility—

"(1) nursing care provided by or under the supervision of a registered professional nurse;

"(2) bed and board in connection with the furnishing of such nursing care;

"(3) physical, occupational, or speech therapy furnished by the extended care facility or by others under arrangements with them made by the facility;

"(4) medical social services;

"(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the extended care facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

Defines "extended care services" as following services furnished to inpatient of extended care facility (with certain exceptions) by the facility: nursing care furnished by or under supervision of RN; bed and board; physical, occupational or speech therapy furnished by facility or by others under arrangements made by facility; medical social services; drugs and supplies ordinarily furnished by facility for care and treatment of inpatients;

services of interns and residents-in-training of hospital with which facility has transfer agreement and under approved teaching program; other diagnostic or therapeutic services of hospital with which such facility has transfer agreement in effect; and other health services generally provided by such facilities. Any service which would not be covered if furnished to inpatient of hospital is excluded.

"(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

"(7) such other services necessary to the health of the patients as are generally provided by extended care facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

"Post-Hospital Extended Care Services

Defines "post-hospital extended care services" as services furnished after transfer from hospital in which individual was inpatient for at least 3 consecutive days before his discharge. Individual deemed to have been transferred from hospital if admitted to extended care facility within 14 days after discharge from hospital. Individual deemed not to have been discharged from an extended care facility if he is readmitted to an extended care facility within 14 days after discharge.

"(i) The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the extended care facility within 14 days after discharge from such hospital; and an individual shall be deemed not to have been discharged from an extended care facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other extended care facility.

"Extended Care Facility

Defines "extended care facility" as institution (or part thereof) which has transfer agreement with one or more participating hospitals and which: (1) primarily provides skilled nursing services for persons requiring medical or nursing care or rehabilitation services; (2) has policies which are developed with advice of and periodically reviewed by professional group (including at least 1 physician and at least 1 RN) to govern services provided; (3) has physician, RN or medical staff responsible for execution of such policies; (4) requires that health care of every patient be under supervision of physician and provides for emergency services by physician; (5) maintains clinical records on all patients; (6) provides 24-hour nursing services sufficient to meet needs in accordance with facility policies and has at least one RN employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals;

"(j) The term 'extended care facility' means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

"(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

"(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

"(5) maintains clinical records on all patients;

"(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

"(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"(8) has in effect a utilization review plan which meets the requirements of subsection (k);

"(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

"(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863);

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term 'extended care facility' also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

(8) has utilization review plan;
(9) is licensed (or meets standards for licensing) pursuant to State or local law; and (10) meets other necessary conditions relating to health, safety or physical facilities.

Term extended care facility does not include any institution primarily for care of mental disease or TB, except for purpose of determining end of spell of illness. For latter purpose any institution which meets requirement (1) is considered extended care facility. The term does include Christian Science sanatorium under certain conditions.

"Utilization Review

"(k) A utilization review plan of a hospital or extended care facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

"(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or extended care facility where, because of the small size of the institution, or (in the case of an

Utilization review plan of hospital or extended care facility acceptable if applicable to services furnished beneficiaries and if provides (1) for review, on sample or other basis, of medical necessity of admissions, duration of stays and professional services; (2) for review to be made by (A) staff committee of institution which includes 2 or more physicians or (B)(i) by similar group outside the institution established by local medical society and by hospitals or extended care facilities in locality (ii) if neither of preceding exists, another approved group; (3) for such review, in each stay of extended duration, as of such days as may be specified, to be made no later than 1 week following such day; (4) for prompt notification to institution, individual and his physician (after opportunity for consultation provided such physician) in case of finding that further stay not medically necessary.

Utilization review plan must provide for review by group outside institution where, because of small size or, in case of extended care facility, lack of organized medical staff, or other reasons, it is impracticable for institution to have properly functioning staff committee.

extended care facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

Hospital and extended care facility considered to have transfer agreement if written agreement provides for: (1) transfer of patients between facilities whenever medically appropriate; and (2) transfer between facilities of medical and other information needed for patients' care.

"Agreements for Transfer Between Extended Care Facilities and Hospitals

"(l) A hospital and an extended care facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Extended care facility may be deemed to have agreement in effect if appropriate State agency of State in which facility is located, or Secretary (in case of State which does not have agreement with Secretary) finds that facility attempted in good faith to enter into transfer agreement with a hospital and allowing participation is in the public interest.

Any extended care facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

"Home Health Services

Defines "home health services" as services and medical supplies furnished in patient's residence on visiting basis by home health agency (or by others under arrangements made by such agency with them) under plan established and supervised by physician; includes part-time nursing care by or under supervision of RN; physical, occupational and speech therapy; medical social services; part-time home health aide services to extent permitted by regulation; and medical services of interns and residents-in-training under approved teaching program of hospital with which agency is affiliated. Includes above items and services provided on outpatient basis at hospital, extended care facility, or rehabilitation center when necessary equipment is of such nature it cannot readily be taken to patient's residence. Excludes drugs and biologicals, and any item or service which would not be covered if furnished to inpatient of hospital.

"(m) The term 'home health services' means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

"(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

"Post-Hospital Home Health Services

"(n) The term 'post-hospital home health services' means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from an extended care facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or extended care facility.

Defines "post-hospital home health services" as services furnished under plan (established within 14 days after discharge from hospital or extended care facility) and within one year after patient's most recent discharge from hospital (in which he was inpatient for at least 3 consecutive days) or, if later, within one year after most recent discharge from extended care facility of which he was inpatient entitled to payment under part A.

"Home Health Agency

"(o) The term 'home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

"(5) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be

Defines "home health agency" as public or private organization which: (1) primarily provides skilled nursing or therapeutic services; (2) has policies established by professional group (including at least one physician and one RN) to govern services and provide for supervision of such services by physician or RN; (3) maintains clinical records; (4) is licensed (or meets standards for licensing) pursuant to State or local law; (5) meets other conditions necessary for health and safety.

Term "home health agency" also includes private organizations which are not nonprofit, which are licensed under State law and which meet additional standards and requirements prescribed in regulations, except that for part A such term does not include any agency or organization which is primarily for care and treatment of mental disease.

prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Defines "outpatient hospital diagnostic services" as services ordinarily furnished to outpatients for purposes of diagnostic study by the hospital or by others under arrangements made by the hospital, provided that services are furnished in facilities supervised by hospital or its organized medical staff and furnished by or under responsibility of hospital's medical staff. Excludes any service which would not be covered if furnished to inpatient.

"Outpatient Hospital Diagnostic Services

"(p) The term 'outpatient hospital diagnostic services' means diagnostic services—

"(1) which are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital; and

"(2) which are ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

excluding, however—

"(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

"(4) any services furnished under such arrangements unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

Defines "physicians' services" as physicians' professional services, including surgery, consultation, and home, office, and institutional calls. Excludes services provided by an intern or resident-in-training under an approved teaching program.

"Physicians' Services

"(q) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in the last sentence of subsection (b)).

"Physician

Defines "physician" as doctor of medicine or osteopathy licensed by State to practice medicine and surgery. Term also includes doctors of dentistry but only with respect to specified procedures.

"(r) The term 'physician', when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), or (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone.

"Medical and Other Health Services

Defines "medical and other health services" as the following items or services (unless they otherwise constitute inpatient hospital, extended care or home health services):
(1) physicians' services;
(2) services and supplies furnished incident to physicians' services (including certain drugs);

"(s) The term 'medical and other health services' means any of the following items or services (unless they would otherwise constitute inpatient hospital services, extended care services, or home health services):

"(1) physicians' services;

"(2) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicans' bills, and hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

"(3) diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;

"(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

"(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

"(6) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home);

"(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

"(8) prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices; and

"(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (3) unless such laboratory—

"(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

"(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

"Drugs and Biologicals

"(t) The term 'drugs' and the term 'biologicals', except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

"Provider of Services

"(u) The term 'provider of services' means a hospital, extended care facility, or home health agency.

"Reasonable Cost

"(v)(1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding

(3) diagnostic x-ray, diagnostic laboratory, and other diagnostic tests;

(4) x-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings and devices for reduction of fractures and dislocations;

(6) rental of durable medical equipment used in patient's residence;

(7) ambulance service, to extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of internal body organ; and

(9) limb, back, and neck braces and artificial limbs and eyes.

No diagnostic tests performed in laboratory independent of physician's office covered unless laboratory meets State standards and meets other necessary conditions relating to health and safety of individuals.

Defines "drugs" and "biologicals" (except for purposes of exclusion of drugs and biologicals under home health services) as those included in the U.S. Pharmacopoeia, National Formulary, U.S. Homeopathic Pharmacopoeia, New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated therein), or approved for use in hospital by pharmacy and drug therapeutics or equivalent staff committee of hospital.

Defines "provider of services" as hospital, extended care facility or home health agency.

Defines "reasonable cost" of services. Requires detailed spelling out of determination method in regulations. Reimbursement principles developed by national organizations or established prepayment organizations must be considered.

Regulations may provide for determination of costs on per diem, per unit, per capita or other basis, may provide for using different methods in different circumstances, for use of estimates of costs of particular items or services, and may provide for use of charges or percentage of charges where this method reasonably reflects costs.

Regulations must take into account direct and indirect costs so that costs with respect to covered individuals will not be borne by noncovered individuals and costs with respect to noncovered individuals will not be borne by insurance programs and provide for making retroactive corrective adjustments where reimbursement inadequate or excessive.

If patient receives services in a accomodations more expensive than semi-private, payments limited to cost of semi-private accomodations unless more expensive accomodations medically necessary.

If patient receives items and services more expensive than those for which payment can be made, Secretary will pay no more than reasonable cost of services that can be paid for.

If patient does not request but is placed in ward accomodations for a reason not consistent with program's purpose, payment will equal cost of semi-private services minus difference between customary charges for semi-private and ward accomodations.

Defines "semi-private accomodations" as two-bed, three-bed, or four-bed accomodations.

sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

"(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

"(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

"(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or extended care facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

"(4) For purposes of this subsection, the term 'semi-private accommodations' means two-bed, three-bed, or four-bed accommodations.

"Arrangements for Certain Services

"(w) The term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, extended care facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

Defines "arrangements" as those under which receipt of payment by provider of services for covered services discharges liability of patient or any other person to pay for services.

"State and United States

"(x) The terms 'State' and 'United States' have the meaning given to them by subsections (h) and (i), respectively, of section 210.

The terms "State" and "United States" mean 50 States, District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.

"Post-Hospital Extended Care in Christian Science Extended Care Facilities

"(y)(1) The term 'extended care facility' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

Definition of "extended care facility" also includes Christian Science sanatorium operated, or listed and certified, by Christian Scientist Church but only with respect to items and services ordinarily furnished inpatients by such institution as and only as provided by regulations.

"(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in an extended care facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

"(A) furnished an individual during such spell of illness in an extended care facility to which paragraph (1) applies after—

"(i) such services have been furnished to him in such a facility for 30 days during such spell, or

"(ii) such services have been furnished to him during such spell in an extended care facility to which such paragraph does not apply; or

"(B) furnished an individual during such spell of illness in an extended care facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in an extended care facility to which such paragraph applies.

Payment for extended care services may not be made for services furnished in Christian Science sanatorium unless individual elects to have such payment made in spell of illness and he has not been furnished services in extended care facility not a Christian Science sanatorium. Such services are covered for not over 30 days in spell of illness. No payment made for services furnished in extended care facility which is not a Christian Science sanatorium after extended care services have been furnished in extended care facility which is Christian Science sanatorium.

"(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in an extended care facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(4)).

Payment for each day of post-hospital extended care in Christian Science extended care facilities during spell of illness reduced by coinsurance amount equal to one-eighth of inpatient hospital deductible ($5 until 1/1/68).

"(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Determination of whether services furnished by Christian Science extended care facility constitute post-hospital extended care services made under conditions specified in regulations.

No payment made under part A or part B for any of following services:
(1) which are not reasonable and necessary for diagnosis or treatment;
(2) for which individual has no legal obligation to pay and which no other person (because of membership in prepayment plan or otherwise) has legal obligation to provide or pay for;
(3) which are paid for by governmental entity (except items and services covered under governmental health insurance plans for employees with other exemptions made by Secretary);
(4) which are not provided within U.S. (except for certain emergency services--see page 12);
(5) which are required as result of act of war occurring after effective date of coverage;
(6) personal comfort items;
(7) routine physical checkups, eyeglasses or hearing aids or examinations therefore, or immunizations;
(8) orthopedic shoes and other supportive devices for the fees;
(9) custodial care;
(10) services for or in connection with cosmetic surgery (except for prompt repair of accidental injury);
(11) where expenses constitute charges by immediate relatives or members of household of patient; or
(12) where expenses are in connection with usual tooth care.

No payment for any item to the extent that payment has been, or can be expected to be made, under workmen's compensation.

Secretary required to consult with HIB Advisory Council, State agencies, and national listing or accrediting bodies and may consult with appropriate local agencies in prescribing such conditions for participation as may be necessary for health and safety. Conditions may be varied for different areas or classes of institutions, and may be set higher for a State at its request (except that where State imposes higher conditions for participation in its medical assistance programs, Secretary must impose like conditions for payment of services under health insurance programs).

"EXCLUSIONS FROM COVERAGE

"SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

"(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

"(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in such cases as the Secretary may specify;

"(4) which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in section 1814 (f));

"(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

"(6) which constitute personal comfort items;

"(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or examinations therefor, or immunizations;

"(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

"(9) where such expenses are for custodial care;

"(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

"(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household; or

"(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.

"(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

"CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

"SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(8), (f)(4), (g)(4), (j)(10), and (o)(5) of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies,

and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

"USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

Secretary must use able and willing State agencies or appropriate local agencies for purposes of determining whether institution or agency is provider of services or whether independent laboratory meets the requirements. He may accept findings of State agencies as to eligibility of providers to participate.

"SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or extended care facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, extended care facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. The Secretary may also, pursuant to agreement, utilize the services of State health agencies and other appropriate State agencies (and the appropriate local agencies) to do any one or more of the following: (1) to provide consultative services to institutions or agencies to assist them (A) to establish and maintain fiscal records necessary for purposes of this title, or otherwise to qualify as hospitals, extended care facilities, or home health agencies, or (B) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof, and (2) to provide consultative services to institutions, agencies, or organizations to assist in the establishment of utilization review procedures meeting the requirements of section 1861(k) and in evaluating their effectiveness.

Secretary may use State and local agencies (1) to provide consultative services to providers to assist them (A) to keep fiscal records and to qualify for participation; (B) provide information necessary to determine whether payments are due and amounts thereof, and (2) to provide consultative services to assist in applying utilization review procedures.

"(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

States reimbursed for costs of activities performed and for fair share of State's costs of coordination of State's programs with program provided for under part A.

"EFFECT OF ACCREDITATION

Except for provision above related to State use of or request for provision of higher requirements, a hospital accredited by Joint Commission deemed to meet all conditions of participation save utilization review. If Commission requires utilization review plan (or equivalent requirement) for accreditation, Secretary may find that accredited hospitals also meet utilization review requirement.

"SEC. 1865. Except as provided in the second sentence of section 1863, an institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals. If such Commission, as

Secretary may accept findings of American Osteopathic Association or other national accrediting body other than Joint Commission as to meeting of conditions of participation.

a condition for accreditation of a hospital, requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861(e)(6). In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

"AGREEMENTS WITH PROVIDERS OF SERVICES

Provider qualified to participate and eligible for payment if it files agreement with Secretary not to charge for covered services and to make provision for refund of erroneous charges.

"SEC. 1866. (a)(1) Any provider of services shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

"(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

"(B) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.

Provider may charge individual for amount of deductibles and coinsurance.

"(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813 (a)(1), (a)(2), or (a)(4), section 1833 (b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or, in the case of outpatient hospital diagnostic services, for which payment is made under part A. In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section.

Provider may charge an individual for extra services furnished at individual's request.

"(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

Provider may charge for first 3 pints of whole blood furnished during spell of illness; charge may not be made for cost of administration of blood and no charge can be made if blood is replaced.

"(C) A provider of services may also charge any such individual for any whole blood furnished him with respect to which a deductible is imposed under section 1813(a)(3), except that (i) any excess of such charge over the cost to such provider for the blood shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such

blood, and (iii) such charge may not be made to the extent such blood has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

"(b) An agreement with the Secretary under this section may be terminated—

"(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

"(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Agreement may be terminated by provider, time and notice to be prescribed by regulation. Secretary may require agreement to remain in effect for up to 6 months after provider notice. Secretary may terminate only if provider (a) not complying with agreement or law, (b) no longer eligible to participate, or (c) fails to provide data to determine amount of payment due, or refuses access to records for verification.

Any termination shall be applicable—

"(3) in the case of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after the effective date of such termination,

"(4)(A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

"(5) with respect to any other items and services furnished on or after the effective date of such termination.

Termination of agreement with provider effective with respect to (1) inpatient hospital services (including TB and psychiatric hospital services) and post-hospital extended care services furnished to individual admitted on or after effective date of termination, (2) home health services furnished under a plan established on or after effective date of termination or, if plan established before the effective date, services furnished after calendar year in which termination effective, (3) any other items or services furnished on or after effective date of termination.

"(c) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

If Secretary terminates agreement, provider may not file new agreement unless Secretary finds reason for termination is removed and there is assurance it will not recur.

"(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or extended care facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of an extended care facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness

If Secretary finds timely reviews of long-stay cases not being made by hospital or extended care facility, Secretary may, in lieu of terminating agreement, deny payment for services furnished after 21st day of continuous inpatient hospital care or after stays of a prescribed length in extended care facility. Such decision may be made only after notice to provider and public and must be rescinded when reviews are being made and there is assurance reviews will continue to be made.

shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

"HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Creates Health Insurance Benefits Advisory Council of 16 persons not otherwise in employ of U.S., to be appointed by Secretary.

"SEC. 1867. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of 16 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 4 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

The Council includes people who are outstanding in fields related to hospital, medical, and other health activities, and at least one person representative of general public. Members serve 4-year terms and may not serve for more than two consecutive terms.

Members receive compensation at rates fixed by Secretary (not exceeding $100 a day).

Council meets as frequently as Secretary finds necessary; he must call a meeting upon request of 4 members.

"NATIONAL MEDICAL REVIEW COMMITTEE

Creates National Medical Review Committee of 9 persons not otherwise in employ of U.S., to be appointed by Secretary. Members to be selected from among individuals representative of organizations and associations and other experts in field of medicine or related fields; at least 1 member represents general public, and at least majority of members to be physicians. Members serve 3-year term and may not serve continuously for more than two terms.

"SEC. 1868. (a) There is hereby created a National Medical Review Committee (hereinafter in this section referred to as the 'Committee') which shall consist of nine persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as chairman. The members shall be selected from among individuals who are representative of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; except that at least one member shall be representative of the general public, and at least a majority of the members shall be physicians. Each member shall hold office for a term of three years, except

that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, three at the end of the second year, and three at the end of the third year after the date of appointment. A member shall not be eligible to serve continuously for more than two terms.

"(b) Members of the Committee, while attending meetings or conferences thereof or otherwise serving on business of the Committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

Members receive compensation at rates fixed by Secretary (not exceeding $100 a day).

"(c) It shall be the function of the Committee to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Committee shall make an annual report to the Secretary of the results of its study, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.

Committee's function to study utilization of hospital and other medical care and services and to recommend desirable changes in utilization, or in administration of program, or in provisions of law. Committee required to make annual report of its study and recommendations.

"(d) The Committee is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Committee such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Committee may require to carry out its functions.

Committee authorized to engage technical assistance. Secretary to make available needed assistance and data.

"DETERMINATIONS; APPEALS

"SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

Determinations of entitlement to benefits under part A and part B, and benefit amounts under part A made by Secretary in accordance with regulations.

"(b) Any individual dissatisfied with any determination under subsection (a) as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Any individual dissatisfied with determination as to entitlement under part A or part B or as to amount under part A is entitled to the same hearings procedure (if amount in issue is $100 or more) and the same appeal and judicial review (if amount in issue is $1,000 or more) as is applicable for cash social security benefits.

"(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Any institution or agency dissatisfied with determination by Secretary that it is not provider of services, or with determination terminating an agreement is entitled to hearing and appeal and to judicial review.

Payment to provider for services furnished individual considered payment to individual.

Where overpayment is made to provider and cannot be recouped from provider, or payment is made for individual not entitled to benefits because of limits on durations, subsequent cash OASI benefits or railroad retirement benefits payable to individual (or, if such individual dies, benefits to others based on his earnings) reduced in accordance with regulations prescribed by Secretary (after consultation with Railroad Retirement Board).

No reduction in cash benefits to be made in any case in which individual is without fault, or reduction would defeat purposes of social security or would be against equity and good conscience.

Certifying or disbursing officer not liable for overpayments where recovery of such payments is waived or where recovery not completed prior to death of all persons against whose benefits recovery authorized.

Secretary will prescribe regulations necessary to carry out administration of programs under title XVIII. Defines "regulations" as regulations prescribed by Secretary of HEW unless context otherwise requires.

"OVERPAYMENTS ON BEHALF OF INDIVIDUALS

"SEC. 1870. (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

"(b) Where—

"(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

"(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

"(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, or

"(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made.

"(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

"(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

"REGULATIONS

"SEC. 1871. The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary.

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1872. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

Provisions of Social Security Act relating to Secretary's recognition of representatives of claimants and relating to penalties and procedures also apply to the health insurance programs.

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"SEC. 1873. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

Designation in Act of a nongovernmental organization or publication by name will not be affected by change of name if Secretary finds successor serves purpose for which designation was made.

"ADMINISTRATION

"SEC. 1874. (a) Except as otherwise provided in this title, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

Provides that, except as otherwise stated, health insurance programs are to be administered by Secretary, who may perform any of his functions directly or by contract.

"(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

The Secretary may contract to secure special data necessary in carrying out his functions.

"STUDIES AND RECOMMENDATIONS

"SEC. 1875. (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

The Secretary is to make studies and develop recommendations relating to health care of aged, including studies and recommendations concerning adequacy of existing personnel and facilities for purposes of health insurance programs; methods for encouraging further development of efficient alternatives to inpatient hospital care; effects of deductibles and coinsurance on beneficiaries, providers of services and financing of program.

"(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B, and shall transmit to the Congress annually a report concerning the operation of such programs."

The Secretary makes continuing study of operations and administration of health insurance programs and submits to Congress annual report.

(b) If—

(1) an individual was eligible to enroll under section 1837(c) of the Social Security Act before April 1, 1966, but failed to enroll before such date, and

(2) it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for such failure to enroll before April 1, 1966,

such individual may enroll pursuant to this subsection at any time before October 1, 1966. The determination of what constitutes good cause for purposes of the preceding sentence shall be made in accordance with regulations of the Secretary. In the case of any individual who enrolls pursuant to this subsection, the coverage period (within the meaning of section 1838 of the Social Security Act) shall begin on the first day of the 6th month after the month in which he so enrolls.

(Sec. 102b) provides if individual was eligible to enroll under supplementary medical insurance before April 1, 1966, but failed to do so but there was good cause for failure to enroll, such individual may enroll any time before October 1, 1966. The coverage period of individual enrolled under this provision will begin on first day of sixth month after month in which he enrolls.

Anyone who--
(1) has attained age 65 before 1968 (or has three quarters of coverage for each calendar year after 1965 and before reaching age 65),
(2) is not entitled to hospital insurance benefits as a social security or railroad retirement beneficiary,
(3) is a resident of U.S. and is a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for at least 5 years prior to the month he files an application,
(4) and has filed an application, will be entitled to hospital insurance benefits beginning with month he meets these requirements and ending with month in which he dies or, if earlier, month before month in which he becomes eligible for hospital insurance benefits as a social security or railroad retirement beneficiary.

Any individual who would have met preceding requirements in any month if he had filed an application before end of that month will be deemed to have met requirements for that month if he files before end of the next 12 months. No application is valid if filed more than 3 months before first month individual is entitled to hospital insurance benefits.

Protection not furnished to person who--
(1) is member of subversive organizations,
(2) has been convicted of subversive activities, or
(3) is covered under the Federal Employees Health Benefits Act of 1959, was so covered on February 16, 1965, or

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

SEC. 103. (a) Anyone who—

(1) has attained the age of 65,

(2) (A) attained such age before 1968, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(1) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1965 and before the year in which he attained such age,

(3) is not, and upon filing application for monthly insurance benefits under section 202 of the Social Security Act would not be, entitled to hospital insurance benefits under section 226 of such Act, and is not certifiable as a qualified railroad retirement beneficiary under section 21 of the Railroad Retirement Act of 1937 (as added by section 105(a) of this Act),

(4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or becomes certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of such month shall be deemed to have met such requirements in such month if he files such application before the end of the twelfth month following such month. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) The provisions of subsection (a) shall not apply to any individual who—

(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 210(a)(17) of the Social Security Act,

(2) has, prior to the beginning of such first month, been convicted of any offense listed in section 202(u) of the Social Security Act, or

(3) (A) at the beginning of such first month is covered by an enrollment in a health benefits plan under the Federal Employees Health Benefits Act of 1959,

(B) was so covered on February 16, 1965, or

(C) could have been so covered for such first month if he or some other person had availed himself of opportunities to enroll in a health benefits plan under such Act and to continue such enrollment (but this subparagraph shall not apply unless he or such other person was a Federal employee at any time after February 15, 1965).

could have been covered if he or some other person had availed himself of opportunities to enroll in a health benefits plan and to continue such enrollment after retirement (but only with respect to those persons who were Federal employees after February 15, 1965).

Paragraph (3) shall not apply in the case of any individual for the month (or any month thereafter) in which coverage under such a health benefits plan ceases (or would have ceased if he had had such coverage) by reason of his or some other person's separation from Federal service, if he or such other person was not (or would not have been) eligible to continue such coverage after such separation.

Exclusion of certain Federal employees not applicable if coverage under Federal Employees Health Benefits Act of 1959 ceases by reason of individual's separation from Federal service and his ineligibility to continue his coverage after separation.

(c) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under part A of title XVIII of such Act with respect to individuals who are entitled to hospital insurance benefits under section 226 of such Act solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the preceding subsections of this section had not been enacted.

Payment of cost of hospital insurance for people not eligible under OASDI or railroad retirement systems made from Federal general revenues.

SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

OASDI provisions suspending payment of benefits to certain aliens outside U.S. made applicable to hospital insurance program.

SEC. 104. (a)(1) Section 202(t) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(9) No payments shall be made under part A of title XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against payment of benefits to him is applicable (or would be if he were entitled to any such benefits)."

(2) Section 202(u) of such Act is amended by striking out "and" before the phrase "in determining the amount of any such benefit payable to such individual for any such month," and inserting after such phrase "and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month,".

(b)(1) No payments shall be made under part B of title XVIII of the Social Security Act with respect to expenses incurred by an individual during any month for which such individual may not be paid monthly benefits under title II of such Act (or for which such monthly benefits would be suspended if he were otherwise entitled thereto) by reason of section 202(t) of such Act (relating to suspension of benefits of aliens who are outside the United States).

Payments may not be made under part B with respect to expenses incurred by an individual during any month for which such individual may not receive monthly social security benefits by reason of the provisions of the Social Security Act relating to suspension of benefits of aliens who are outside the U.S.

(2) An individual who has been convicted of any offense under (A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition,

and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended, may not enroll under part B of title XVIII of the Social Security Act.

Adds new section 21 to Railroad Retirement Act.

New section 21 of RR Act provides that for purpose of providing hospital insurance benefits for RR beneficiaries RR Board certifies to Secretary of HEW, upon Secretary's request, name of any individual who has attained age 65 and (1) is entitled to annuity or pension under the RR Act, or (2) would be entitled to such annuity or pension if he (or a spouse's husband) ceased compensated service and applied for such annuity, or (3) bears relationship to an employee which would be taken into account under "social security minimum" provision of RR Act in annuity computation. Certification made by Board to Secretary of HEW shall include additional necessary information and shall be effective on date of certification, or on such earlier date not more than one year prior to certification date as Board states individual first met requirements. Board shall notify Secretary of date when such individual no longer meets requirements.

Provides that for purposes of new section 21 of RR Act of 1937 (and sections of the SS Act relating to health insurance benefits for aged) entitlement to annuity or pension under RR Act of 1937 shall be deemed to include entitlement under RR Act of 1935.

Amends section 3201 of the IRC (relating to rate of tax on employees under RR Act) so that provision in RR Tax Act that automatically increases the RR employee tax rates in same amount, and at same time, as any SS contribution rate increases that go into effect after 1964 shall apply only to increases in OASDI contribution rates. (This amendment takes into account fact that unless certain conditions are met hospital insurance taxes are levied directly on railroad employees under the Federal Insurance Contributions Act.) See page 55.

Amends section 3211 of IRC (relating to rate of tax on employee representatives under RR Act) so that provision in RR Tax Act that automatically increases RR employee representative tax rates in same amount, and at same time, as any SS contribution rate increases that go into effect after 1964 shall apply only to increases in the OASDI contribution rates. (This amendment takes into account fact that unless certain conditions are met hospital insurance taxes are levied directly on railroad employee representatives under Federal Insurance Contributions Act). See page 55.

RAILROAD RETIREMENT AMENDMENTS

SEC. 105. (a) (1) The Railroad Retirement Act of 1937 is amended by adding after section 20 the following new section:

"HOSPITAL INSURANCE BENEFITS FOR THE AGED

"SEC. 21. For the purposes of part A of title XVIII of the Social Security Act, in order to provide hospital insurance benefits for annuitants, pensioners, and certain other aged individuals, the Board shall, upon request of the Secretary of Health, Education, and Welfare, certify to the Secretary the name of any individual who has attained age 65 and who (1) is entitled to an annuity or pension under this Act, (2) would be entitled to such an annuity had he (i) ceased compensated service and (in the case of a spouse) had such spouse's husband or wife ceased compensated service and (ii) applied for such annuity, or (3) bears a relationship to an employee which, by reason of section 3(e) of this Act, has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivors. Such a certification shall include such additional information as may be necessary to carry out the provisions of part A of title XVIII of the Social Security Act, and shall become effective on the date of certification or on such earlier date not more than one year prior to the date of certification as the Board states that such individual first met the requirements for certification. The Board shall notify the Secretary of the date on which such individual no longer meets the requirements of this section."

(2) For purposes of section 21 of the Railroad Retirement Act of 1937 (and sections 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 shall be deemed to include entitlement under the Railroad Retirement Act of 1935.

(b) (1) Section 3201 of the Internal Revenue Code of 1954 (relating to rate of tax on employees under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3101 at such time exceeds the rate provided by paragraph (2) of such section 3101 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3101(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3101 as amended by the Social Security Amendments of 1956)".

(2) Section 3211 of such Code (relating to the rate of tax on employee representatives under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3101 at such time exceeds the rate provided by paragraph (2) of such section 3101 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3101(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3101 as amended by the Social Security Amendments of 1956)".

(3) Section 3221(b) of such Code (relating to the rate of tax on employers under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3111 at such time exceeds the rate provided by paragraph (2)

of such section 3111 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3111(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3111 as amended by the Social Security Amendments of 1956)".

(4) The amendments made by this subsection shall be effective with respect to compensation paid for services rendered after December 31, 1965.

(c) For amendments preserving relationship between the railroad retirement and old-age, survivors, and disability insurance systems, see section 326 of this Act.

Amends section 3221(b) of IRC (relating to rate of tax on employers under RR Act) so that provision in the RR Tax Act that automatically increases RR employer tax rates in same amount, and at same time, as any SS contribution rate increases that go into effect after 1964 shall apply only to increases in OASDI contribution rates. (This amendment takes into account the fact that unless certain conditions are met hospital insurance taxes are levied directly on railroad employers under the FICA.) See page 55.

Provides that amendments made by this section relating to RR taxes shall be effective with respect to services rendered after December 31, 1965.

MEDICAL EXPENSE DEDUCTION

SEC. 106. (a) Subsection (a) of section 213 of the Internal Revenue Code of 1954 (relating to allowance of deduction) is amended to read as follows:

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise—

"(1) the amount by which the amount of the expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for medical care of the taxpayer, his spouse, and dependents (as defined in section 152) exceeds 3 percent of the adjusted gross income, and

"(2) an amount (not in excess of $150) equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents."

(b) The second sentence of section 213(b) of such Code (relating to limitation with respect to medicine and drugs) is repealed.

(c) Section 213(e) of such Code (relating to definitions) is amended by renumbering paragraph (2) as paragraph (4), and by striking out paragraph (1) and inserting in lieu thereof the following:

"(1) The term 'medical care' means amounts paid—

"(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

"(B) for transportation primarily for and essential to medical care referred to in subparagraph (A), or

"(C) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B).

"(2) In the case of an insurance contract under which amounts are payable for other than medical care referred to in subparagraphs (A) and (B) of paragraph (1)—

"(A) no amount shall be treated as paid for insurance to which paragraph (1)(C) applies unless the charge for such insurance is either separately stated in the contract, or furnished to the policyholder by the insurance company in a separate statement,

"(B) the amount taken into account as the amount paid for such insurance shall not exceed such charge, and

"(C) no amount shall be treated as paid for such insurance if the amount specified in the contract (or furnished to the

policyholder by the insurance company in a separate statement) as the charge for such insurance is unreasonably large in relation to the total charges under the contract.

"(3) Subject to the limitations of paragraph (2), premiums paid during the taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care (within the meaning of subparagraphs (A) and (B) of paragraph (1)) for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 shall be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years)."

(d)(1) Section 213 of such Code (relating to medical, dental, etc., expenses) is amended by striking out subsections (c) and (g) of such section.

(2)(A) Section 72(m)(5)(A)(i) of such Code (relating to special rules applicable to employment annuities and distributions under employee plans) is amended by striking out "section 213(g)(3)" and inserting in lieu thereof "paragraph (7) of this subsection".

(B) Section 72(m) of such Code is further amended by adding at the end thereof the following new paragraph:

"(7) MEANING OF DISABLED.—For purposes of this section, an individual shall be considered to be disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. An individual shall not be considered to be disabled unless he furnishes proof of the existence thereof in such form and manner as the Secretary or his delegate may require."

(C) Subparagraphs (A)(iii) and (B)(iii) of section 72(n)(1) of such Code (relating to treatment of certain distributions with respect to contributions by self-employed individuals) are each amended by striking out "section 213(g)(3)" and inserting in lieu thereof "subsection (m)(7)".

(3) Section 79(b)(1) of such Code (relating to group-term life insurance purchased for employees) is amended by striking out "paragraph (3) of section 213(g), determined without regard to paragraph (4) thereof" and inserting in lieu thereof "section 72(m)(7)".

(4) Section 401(d)(4)(B) of such Code (relating to additional requirements for qualification of trusts and plans benefiting owner-employees) is amended by striking out "section 213(g)(3)" and inserting in lieu thereof "section 72(m)(7)".

(5) Section 405(b)(1)(D)(ii) of such Code (relating to qualified bond purchase plans) is amended by striking out "section 213(g)(3)" and inserting in lieu thereof "section 72(m)(7)".

(e) The amendments made by this section shall apply to taxable years beginning after December 31, 1966.

RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

Employee's copy of W-2 must show amount of taxes withheld for financing cost of hospital insurance benefits under part A.

SEC. 107. Section 6051(c) of the Internal Revenue Code of 1954 (relating to additional requirements) is amended by adding at the end thereof the following new sentence: "The statements required under this section shall also show the proportion of the total amount

withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act."

Excludes employer and employee taxes for hospital insurance from the employer and employee taxes appropriated to OASI Trust Fund.

TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

SEC. 108. (a)(1) Section 201(a)(3) of the Social Security Act is amended by inserting "(other than sections 3101(b) and 3111(b))" after "chapter 21" each place it appears therein.

(2) Section 201(a)(4) of such Act is amended by inserting "(other than section 1401(b))" after "chapter 2" and after "such subchapter or chapter".

Excludes self-employment taxes for hospital insurance from self-employment taxes appropriated to OASI Trust Fund.

(3) Section 201(g)(1) of such Act is amended to read as follows:

"(1)(A) There are authorized to be made available for expenditure, out of any or all of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII), such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this title and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. During each fiscal year or after the close of such fiscal year (or at both times), the Secretary of Health, Education, and Welfare shall analyze the costs of administration of this title and title XVIII during the appropriate part or all of such fiscal year in order to determine the portion of such costs which should be borne by each of the Trust Funds and shall certify to the Managing Trustee the amount, if any, which should be transferred among such Trust Funds in order to assure that each of the Trust Funds bears its proper share of the costs incurred during such fiscal year for the part of the administration of this title and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. The Managing Trustee is authorized and directed to transfer any such amount (determined under the preceding sentence) among such Trust Funds in accordance with any certification so made.

Provides for payment from Trust Funds of costs to DHEW of administering health insurance program and for adjustments among trust funds so that each fund bears its proportionate share of such costs.

"(B) The Managing Trustee is directed to pay from the Trust Funds into the Treasury the amounts estimated by him which will be expended, out of moneys appropriated from the general funds in the Treasury, during each calendar quarter by the Treasury Department for the part of the administration of this title and title XVIII for which the Treasury Department is responsible and for the administration of chapters 2 and 21 of the Internal Revenue Code of 1954. Such payments shall be covered into the Treasury as repayment to the account for reimbursement of expenses incurred in connection with such administration of this title and title XVIII and chapters 2 and 21 of the Internal Revenue Code of 1954."

Provides for payments from Trust Funds to the Treasury to meet estimated quarterly costs to the Treasury of health insurance administration and of chapters 2 (Tax on Self-Employment) and 21 (Tax on Wages) of the Internal Revenue Code of 1954.

(4) Section 201(g)(2) of such Act is amended by inserting after "the amount estimated by him as taxes" the following: "imposed under section 3101(a)".

In estimating the amount of employee taxes subject to refund Managing Trustee shall consider only taxes imposed for support of the OASI and DI programs. (Thereby taking account of the special provisions of the health insurance program for same purpose.)

(5) Section 201(h) of such Act is amended by inserting "(other than section 226)" after "this title".

Payments for hospital insurance benefits may not be made from OASDI Trust Funds.

(b) Section 218(h)(1) of such Act is amended by striking out "Trust Funds in the ratio in which amounts are appropriated to such Funds pursuant to subsections (a)(3) and (b)(1) of section 201" and inserting in lieu thereof "Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a)(3) of section 201, subsection (b)(1) of such section, and subsection (a)(1) of section 1817, respectively".

Provides for proportionate deposits in Hospital Insurance Trust Fund as well as in existing trust funds of amounts received by Secretary of the Treasury under agreements for coverage of State and local government employees.

The health insurance trust funds, like the OASI and DI trust funds, may be reimbursed for costs of furnishing information (disclosure of which is authorized by regulations) or services to individuals or organizations.

(c) Section 1106(b) of such Act is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund".

ADVISORY COUNCIL ON SOCIAL SECURITY

Provides for appointment of an Advisory Council in 1968 and every 5th year thereafter to review status of the 4 trust funds and all other aspects of the OASDI, HI, and SMIB programs, including their impact on public assistance programs. (Prior law provided for appointment of Council in 1966 and every 5th year thereafter to review only financing of OASDI program.)

SEC. 109. (a) Title VII of the Social Security Act is amended by adding at the end thereof the following new section:

"ADVISORY COUNCIL ON SOCIAL SECURITY

"SEC. 706. (a) During 1968 and every fifth year thereafter, the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

Council consists of 12 members appointed by Secretary plus the Commissioner of Social Security as Chairman. Members represent organizations of employers and employees in equal numbers as well as the self-employed and the public.

"(b) Each such Council shall consist of the Commissioner of Social Security, as Chairman, and 12 other persons, appointed by the Secretary without regard to the civil service laws. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

Council has authority to engage outside assistance.

"(c)(1) Any Council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

The members of the Council may be paid travel expenses and up to $100 a day in salary.

"(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government employed intermittently.

"(d) Each such Council shall submit reports of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

Requires the Council to submit its report--including separate reports on (1) the OASDI program, (2) the HI program, and (3) the SMIB program.

"(1) a separate report with respect to the old-age, survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954,

"(2) a separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

"(3) a separate report with respect to the supplementary medical insurance program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the Council shall cease to exist."

(b) Effective January 1, 1966, section 116(e) of the Social Security Amendments of 1956 is repealed.

MEANING OF TERM "SECRETARY"

SEC. 110. As used in this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary", unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

ROLE OF THE RAILROAD RETIREMENT BOARD IN THE ADMINISTRATION OF HOSPITAL INSURANCE FOR THE AGED

SEC. 111. (a) The first sentence of section 1874(a) of the Social Security Act is amended to read as follows: "Except as otherwise provided in this title and in the Railroad Retirement Act of 1937, the insurance programs established by this title shall be administered by the Secretary."

Amends SS Act to permit RR Board to administer certain phases of hospital insurance program (subject to limitation on effectiveness, p. 58).

(b) (1) Section 21 of the Railroad Retirement Act of 1937 (as added by section 105 of this Act) is amended to read as follows:

"HOSPITAL INSURANCE BENEFITS FOR THE AGED

"SEC. 21. (a) For the purposes of this section, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services (all hereinafter referred to as 'services') under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such section and such parts apply. For purposes of section 11, a determination with respect to the rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

Amends section 21 (created by this law) of RR Act to permit RR Board to make determinations as to rights of RR beneficiaries to hospital insurance benefits. See page 50.

"(b) Except as otherwise provided in this section, every individual who—

"(1) has attained age 65, and

"(2) (A) is entitled to an annuity under this Act, or (B) would be entitled to such an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service, or (C) had been awarded a pension under section 6, or (D) bears a relationship to an employee which, by reason of section 3(e), has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivors,

shall be certified to the Secretary of Health, Education, and Welfare as a qualified railroad retirement beneficiary under section 226 of the Social Security Act.

Sets forth qualifications a person must meet to be found by RR Board to be entitled to hospital insurance benefits. Individual must (1) have reached age 65; and (2) (a) be entitled to railroad retirement annuity, (b) be eligible for an annuity if he should retire, (c) have been awarded railroad pension, or (d) bears relationship to an employee which would be taken into account under "social security minimum" provision of RR Act in annuity computation.

"(c) The Board and the Secretary of Health, Education, and Welfare shall furnish each other with such information, records, and doc-

Provides for such exchanges of information, etc., between RR Board and Secretary of HEW as necessary in administration.

Provides that for certain health insurance benefit purposes, entitlement to an annuity or pension under RR Act of 1937 shall be deemed to include entitlement under RR Act of 1935. (Device to avoid repetitious referral to both Acts.)

Provides for payment of hospital insurance benefits to RR beneficiaries in Canadian hospitals, financed from RR Account, but only to extent that payments exceed amount payable for such services under Canadian law. Provides that for purposes of section 9 of RR Act (on erroneous payments), any overpayment under this provision shall be treated as if it were an overpayment of an annuity.

Amends financial interchange provisions of RR Act providing for transfer of funds between RR Account and SS trust funds with respect to OASI and disability benefits by adding somewhat similar provisions applying to hospital insurance benefits. These provisions specify that exchanges of funds between RR Account and Federal Hospital Insurance Trust Fund will be made which will place Federal Hospital Insurance Trust Fund in same position in which it would have been if railroad employment had been covered under SS program. The main effect of amendment would be to provide for transfer from RR Account to Federal Hospital Insurance Trust Fund of amounts equal to taxes which would have been payable under hospital insurance benefits program if railroad employment had been covered under SS. (Except for payments with respect to RR beneficiaries in Canadian hospitals, all payments with respect to RR beneficiaries would be made from Federal Hospital Insurance Trust Fund.)

uments as may be considered necessary to the administration of this section or section 226, and part A of title XVIII, of the Social Security Act.

"(d) For purposes of this section (and sections 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under this Act shall be deemed to include entitlement under the Railroad Retirement Act of 1935.

"(e) The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in subsection (a) of this section but provided in Canada shall be the same as those of individuals to whom section 226 and part A of title XVIII of the Social Security Act apply, and this subsection shall be administered by the Board as if the provisions of section 226 and part A of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health, Education, and Welfare were to the Board, as if references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included Canada or a subdivision thereof, and as if the provisions of sections 1862(a)(4), 1863, 1864, 1867, 1868, 1869, 1874(b), and 1875 of such title XVIII were not included in such title. The payments for services herein provided for in Canada shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under section 10(b) in making payment of other benefits) to the hospital, extended care facility, or home health agency providing such services in Canada to individuals to whom subsection (b) of this section applies, but only to the extent that the amount of payments for services otherwise hereunder provided for an individual exceeds the amount payable for like services provided pursuant to the law in effect in the place in Canada where such services are furnished. For the purposes of section 9 of this Act, any overpayment under this subsection shall be treated as if it were an overpayment of an annuity."

(2) Section 5(k)(2) of such Act is amended—

(A) by striking out subparagraphs (A) and (B) and redesignating subparagraphs (C), (D), and (E) as subparagraphs (A), (B), and (C), respectively;

(B) by striking out the second sentence and the last sentence of subdivision (i) of the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph; and by striking out from such subdivision (i) "the Retirement Account" and inserting in lieu thereof "the Railroad Retirement Account (hereinafter termed 'Retirement Account')";

(C) by adding at the end of the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph the following new subdivision:

"(iii) At the close of the fiscal year ending June 30, 1966, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Hospital Insurance Trust Fund, would place such fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term 'employment' as defined in the Social Security Act and in the Federal Insurance Contributions Act. Such determination shall be made no later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Hospital Insurance Trust Fund, the Board shall, within ten days after the determination,

certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Hospital Insurance Trust Fund; and if such amount is to be subtracted from the Federal Hospital Insurance Trust Fund the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Hospital Insurance Trust Fund to the Retirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.";

(D) by striking out "subparagraph (D)" where it appears in the subparagraph redesignated as subparagraph (A) by subparagraph (A) of this paragraph, and inserting in lieu thereof "subparagraph (B)";

(E) by striking out "subparagraphs (B) and (C)" where it appears in the subparagraph redesignated as subparagraph (B) by subparagraph (A) of this paragraph and inserting in lieu thereof "subparagraph (A)"; and

(F) by amending the subparagraph redesignated as subparagraph (C) by subparagraph (A) of this paragraph to read as follows:

"(C) The Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund from the Retirement Account or to the Retirement Account from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund, as the case may be, such amounts as, from time to time, may be determined by the Board and the Secretary of Health, Education, and Welfare pursuant to the provisions of subparagraph (A), and certified by the Board or the Secretary of Health, Education, and Welfare for transfer from the Retirement Account or from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund."

(c)(1) Section 3201 of the Internal Revenue Code of 1954 (relating to rate of tax on employees under the Railroad Retirement Tax Act) is amended by striking out "section 3101(a)" and inserting in lieu thereof "section 3101(a) plus the rate imposed by section 3101(b)".

(2) Section 3211 of such Code (relating to the rate of tax on employee representatives under the Railroad Retirement Tax Act) is amended by striking out "section 3101(a)" and inserting in lieu thereof "section 3101(a) plus the rate imposed by section 3101(b)".

(3) Section 3221(b) of such Code (relating to the rate of tax on employers under the Railroad Retirement Tax Act) is amended by striking out "section 3111(a)" and inserting in lieu thereof "section 3111(a) plus the rate imposed by section 3111(b)".

(4) Section 1401(b) (as amended by section 321 of this Act) of such Code (relating to the rate of tax under the Self-Employment Contributions Act) is amended by striking out the last sentence.

(5) Section 3101(b) of such Code (relating to the rate of tax on employees under the Federal Insurance Contributions Act) is amended by striking out ", but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees".

Amends SS and RR taxing provisions of Internal Revenue Code to provide for levy of hospital insurance benefit taxes on RR employment under RR tax provisions of Code (Railroad Retirement Tax Act).

Authorizes appropriations to Federal Hospital Insurance Trust Fund to cover cost of hospital insurance for certain qualified RR beneficiaries who could not qualify for OASDI benefits even if railroad employment were covered under SS. These individuals are pensioners, and persons who qualified for annuities very soon after RR program went into effect, and are in category of persons which section 103 (provision for hospital insurance for certain uninsured aged) covers.

Preceding provisions of section 111 would be effective for any year after 1965 for which RR taxable wage base (i.e., monthly RR wage base multiplied by 12) was scheduled in law on preceding October 1 to be equal to SS wage base. (For such years, hospital insurance taxes on railroad employment will be levied under railroad taxing provisions and transferred to SS, RR Board will make determinations as to rights of RR beneficiaries to hospital insurance, and will provide for and pay for hospital insurance benefits for RR beneficiaries in Canadian hospitals.) Should there be years in which tax bases are not scheduled to be equal, section 111 would not apply; provisions in section 21 without this amendment (page 55) would apply, and hospital insurance taxes for such years would be levied under SS taxing provisions, and hospital insurance benefits for RR beneficiaries would be provided under SS on same basis as for SS beneficiaries.

(6) Section 3111(b) of such Code (relating to the rate of tax on employers under the Federal Insurance Contributions Act) is amended by striking out ", but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees".

(d) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under part A of title XVIII of such Act with respect to individuals who are qualified railroad retirement beneficiaries (as defined in section 226(c) of such Act) and who are not, and upon filing application for monthly insurance benefits under section 202 of such Act would not be, entitled to such benefits if service as an employee (as defined in the Railroad Retirement Act of 1937) after December 31, 1936, had been included in the term "employment" as defined in the Social Security Act,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss of interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the individuals described in paragraph (1) had not been entitled to benefits under part A of title XVIII of the Social Security Act.

(e)(1) The amendments made by the preceding provisions of this section shall apply to the calendar year 1966 or to any subsequent calendar year, but only if the requirement in paragraph (2) has been met with respect to such calendar year.

(2) The requirement referred to in paragraph (1) shall be deemed to have been met with respect to any calendar year if, as of the October 1 immediately preceding such calendar year, the Railroad Retirement Tax Act provides that the maximum amount of monthly compensation taxable under such Act during all months of such calendar year will be an amount equal to one-twelfth of the maximum wages which the Federal Insurance Contributions Act provides may be counted for such calendar year.

Part 2—Grants to States for Medical Assistance Programs

establishment of programs

Sec. 121. (a) The Social Security Act is amended by adding at the end thereof (after the new title XVIII added by section 102) the following new title:

"TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

"appropriation

"Sec. 1901. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or

self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

"STATE PLANS FOR MEDICAL ASSISTANCE

"SEC. 1902. (a) A State plan for medical assistance must—

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

"(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1970, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

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

"(4) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(5) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged);

"(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

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

"(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

"(9) provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;

"(10) provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI; and—

"(A) provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan—

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

"(ii) shall not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals not receiving aid or assistance under any such plan; and

"(B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide—

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

"(ii) that the medical or remedial care and services made available to all individuals not receiving aid or assistance under any such State plan shall be equal in amount, duration, and scope;

except that the making available of the services described in paragraph (4) or (14) of section 1905(a) to individuals meeting the age requirement prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages;

"(11) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan;

"(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

"(13) provide for inclusion of some institutional and some noninstitutional care and services, and, effective July 1, 1967, provide (A) for inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and (B) for

payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

"(14) provide that (A) no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to any other medical assistance furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources;

"(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide—

"(A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and

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

"(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

"(17) include reasonable standards (which shall be comparable for all groups) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, if he met the requirements as to need, be eligible for aid or assistance in the form of money payments under a State plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and amount of such aid or assistance under such plan, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or is blind or permanently and totally disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

One of requirements that State plan must meet to qualify for Federal grants under medical assistance programs is that it provide in the case of eligible persons covered by hospital insurance program, medical insurance program, or both:

(1) for meeting cost of deductible imposed under hospital insurance program; and

(2) where all of deductible, coinsurance, or similar charge imposed under medical insurance plan is not met, for meeting portion of such charges determined on a basis reasonably related to individual's income and resources.

"(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or permanently and totally disabled) of any medical assistance correctly paid on behalf of such individual under the plan;

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

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

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A) (i) and (ii) or section 1603(a)(4)(A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

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

"(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases; and

"(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

"(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

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

"(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under title IV; or

"(3) any residence requirement which excludes any individual who resides in the State; or

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

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this title) provided for eligible individuals under a plan of such State approved under title I, IV, X, XIV, or XVI.

"PAYMENT TO STATES

"SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section and section 1117) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

"(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are recipients of money payments under a State plan approved under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

"(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency (or of the local agency administering the State plan in the political subdivision); plus

"(3) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.

"(c)(1) If the Secretary finds, on the basis of satisfactory information furnished by a State, that the Federal medical assistance percentage for such State applicable to any quarter in the period beginning January 1, 1966, and ending with the close of June 30, 1969, is less than 105 per centum of the Federal share of medical expenditures by the State during the fiscal year ending June 30, 1965 (as determined under paragraph (2)), then 105 per centum of such Federal share shall be the Federal medical assistance percentage (instead of the percentage determined under section 1905(b)) for such State for

such quarter and each quarter thereafter occurring in such period and prior to the first quarter with respect to which such a finding is not applicable.

"(2) For purposes of paragraph (1), the Federal share of medical expenditures by a State during the fiscal year ending June 30, 1965, means the percentage which the excess of—

"(A) the total of the amounts determined under sections 3, 403, 1003, 1403, and 1603 with respect to expenditures by such State during such year as aid or assistance under its State plans approved under titles I, IV, X, XIV, and XVI, over

"(B) the total of the amounts which would have been determined under such sections with respect to such expenditures during such year if expenditures as aid or assistance in the form of medical or any other type of remedial care had not been counted,

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

"(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

"(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

"(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"(e) The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

"OPERATION OF STATE PLANS

"SEC. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"DEFINITIONS

"SEC. 1905. For purposes of this title—

"(a) The term 'medical assistance' means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals who are—

"(i) under the age of 21,

"(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under title IV,

"(iii) 65 years of age or older,

"(iv) blind, or

"(v) 18 years of age or older and permanently and totally disabled,

but whose income and resources are insufficient to meet all of such cost—

"(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

"(2) outpatient hospital services;

"(3) other laboratory and X-ray services;

"(4) skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older;

"(5) physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere;

"(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

"(7) home health care services;

"(8) private duty nursing services;

"(9) clinic services;

"(10) dental services;

"(11) physical therapy and related services;

"(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

"(13) other diagnostic, screening, preventive, and rehabilitative services;

"(14) inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases; and

"(15) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except that such term does not include—

"(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

"(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

"(b) The term 'Federal medical assistance percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 55 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a) (8); except that the Secretary shall promulgate such percentage as soon as possible after the enactment of this title, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1967."

(b) No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act, or for any period after December 31, 1969.

(c) (1) Effective January 1, 1966, section 1101(a) (1) of the Social Security Act is amended by striking out "and XVI" and inserting in lieu thereof "XVI, and XIX".

(2) Section 1109 of such Act is amended to read as follows:

"AMOUNTS DISREGARDED NOT TO BE TAKEN INTO ACCOUNT IN DETERMINING ELIGIBILITY OF OTHER INDIVIDUALS

"SEC. 1109. Any amount which is disregarded (or set aside for future needs) in determining the eligibility of and amount of the aid or assistance for any individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such titles."

(3) Effective January 1, 1966, section 1115 of such Act is amended by striking out "or XVI", "or 1602", and "or 1603" and inserting in lieu thereof "XVI, or XIX", "1602, or 1902", and "1603, or 1903", respectively.

Authorizes Federal financial participation in expenditures by State under OAA, Aid and Services to Needy Families With Children, Aid to the Blind, and Aid to the Permanently and Totally Disabled for premiums paid for supplementary medical insurance.

PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

SEC. 122. Sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act are each amended by inserting "premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other" after "expenditures for" in the parenthetical phrase appearing in so much of paragraph (1) thereof as precedes clause (A), and in the parenthetical phrase appearing in paragraph (2) thereof.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

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

INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

SEC. 201. (a) The first sentence of section 501 of the Social Security Act is amended by striking out "$40,000,000" and all that follows and inserting in lieu thereof "$45,000,000 for the fiscal year ending June 30, 1966, $50,000,000 for the fiscal year ending June 30, 1967, $55,000,000 for the fiscal year ending June 30, 1968, $55,000,000 for the fiscal year ending June 30, 1969, and $60,000,000 for the fiscal year ending June 30, 1970, and each fiscal year thereafter."

(b) Section 504 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder for any period after June 30, 1966, unless it makes a satisfactory showing that the State is extending the provision of maternal and child health services in the State with a view to making such services available by July 1, 1975, to children in all parts of the State."

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INCREASE IN CRIPPLED CHILDREN'S SERVICES

SEC. 202. (a) The first sentence of section 511 of the Social Security Act is amended by striking out "$40,000,000" and all that follows and inserting in lieu thereof "$45,000,000 for the fiscal year ending June 30, 1966, $50,000,000 for the fiscal year ending June 30, 1967, $55,000,000 for the fiscal year ending June 30, 1968, $55,000,000 for the fiscal year ending June 30, 1969, and $60,000,000 for the fiscal year ending June 30, 1970, and each fiscal year thereafter."

(b) Section 514 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this subsection, no payment shall be made to any State thereunder for any period after June 30, 1966, unless it makes a satisfactory showing that the State is extending the provision of crippled children's services in the State with a view to making such services available by July 1, 1975, to children in all parts of the State."

TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

SEC. 203. (a) Part 2 of title V of the Social Security Act is amended by adding at the end thereof the following new section:

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