Calendar No. 389

89TH CONGRESS
1st Session

SENATE

REPT. 404
Part I

SOCIAL SECURITY AMENDMENTS OF 1965

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

TO ACCOMPANY

H.R. 6675

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

TOGETHER WITH

INDIVIDUAL, ADDITIONAL, AND SUPPLEMENTAL VIEWS

PART I

JUNE 30 (legislative day, JUNE 29), 1965.—Ordered to be printed

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PART I

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Mr. LONG of Louisiana, from the Committee on Finance, submitted the following

REPORT

together with

INDIVIDUAL, ADDITIONAL AND SUPPLEMENTAL VIEWS

[To accompany H.R. 6675]

The Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

PART I

I. BRIEF SUMMARY

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

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

Second, to expand the services for maternal and child health, crippled children, child welfare, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children (including those who are emotionally disturbed) of school age or preschool age.

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

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

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

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

(4) liberalizing the definition of disability, providing disabled child's benefits with respect to disability before age 22, providing rehabilitation services for disabled workers, and facilitating determinations of disability;

(5) limiting the duplication of disability benefits and those under workmen's compensation;

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

(7) increasing the amount an individual is permitted to earn without losing benefits;

(8) amending the coverage provisions by—

(*a*) including self-employed physicians;

(*b*) covering cash tips on a self-employment basis;

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

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

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

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

(10) making other miscellaneous improvements.

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

(1) increasing the Federal matching share for cash payments

for the needy aged, blind, disabled, and families with dependent children;

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

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

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

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

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

(2) *Voluntary supplementary plan.*—It is estimated that of the total eligible aged of 19 million, from 80 to 95 percent would participate, which would mean approximately 15 to 18 million individuals would be involved.

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

Old-age, survivors, and disability insurance

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

Provision	*Number of persons*
7-percent benefit increase ($4 minimum in primary benefit)	20,000,000
Reduced age for widows	185,000
Reduction in eligibility requirement for certain persons aged 72 or over	355,000
Modification of definition of disability	60,000
Improvements in benefits for children, total	335,000
Child's benefits to age 22 if in school	295,000
Benefits for children disabled after 18 and before age 22	20,000
Broadened definition of child	20,000
Liberalization of disability definition, workers and dependents	60,000
Liberalization of retirement test, persons	850,000

Public assistance

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

II. PRINCIPAL PROVISIONS OF THE BILL

A. Health Insurance and Medical Care for the Aged

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

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

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

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

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

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

A description of these three programs follows:

1. BASIC PLAN—HOSPITAL INSURANCE

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

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

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

(1) inpatient hospital services for up to 120 days in each spell of illness. The patient pays a deductible amount of $40 for the first 60 days plus $10 a day for any days in excess of 60 for each spell of illness; hospital services would include all those ordinarily furnished by a hospital to its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians *except* (1) services provided by interns or residents in training under approved teaching programs; and (2) services of radiologists, anesthesiologists, pathologists, and physiatrists where these services are provided under an arrangement with the hospital and are billed through the hospital. Inpatient psychiatric hospital service would also be included, but a lifetime limitation of 210 days would be imposed.

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

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

(4) posthospital home health services for up to 175 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when certain equipment is used, the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get advantage of the necessary equipment.

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

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

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1968. The coinsurance amounts for long-stay hospital and extended care facility benefits would be correspondingly adjusted.

For reasons of administrative simplicity, increases in the hospital deductible will be made only when a $4 change is called for and the outpatient deductible will change in $2 steps.

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

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

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

	Percent
1966	0.325
1967–70	.50
1971–72	.55
1973–75	.60
1976–79	.65
1980–86	.75
1987 and after	.85

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

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above $6,600.

The benefits for railroad retirement eligibles will be financed by the railroad retirement tax which is automatically increased by the operation of this bill. However, the railroad retirement wage base (now $450 a month) is not affected by this bill and is not within the jurisdiction of this committee. Until an amendment is adopted to the Railroad Retirement Tax Act increasing their wage base to an amount equivalent to an earnings base of $6,600 per year, the benefits of railroad eligibles will be financed by the hospital insurance tax and administered by the Secretary of Health, Education, and Welfare; thereafter the benefits for railroad eligibles will be administered by the Railroad Retirement Board.

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

2. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

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

Enrollment.—Persons who have reached age 65 before July 1, 1966, will have an opportunity to enroll in an enrollment period which begins April 1, 1966, and shall end on September 30, 1966.

Persons attaining age 65 subsequent to July 1, 1966, will have enrollment periods of 7 months beginning 3 months before the month of attainment of age 65.

In the future, general enrollment periods will be from October 1 to December 31, in each even-numbered year. The first such period will be October 1 to December 31, 1968.

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

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

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

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

Effective date.—Benefits will be effective beginning January 1, 1967.

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

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

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

(2) Chiropractors' services.

(3) Podiatrists' services.

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

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

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

(7) Ambulance services.

(8) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical

equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

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

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

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

The Government would help finance the supplementary plan through a payment from general revenues in an equal amount of $3 a month per enrollee. To provide an operating fund, if necessary, at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in January 1967 when the supplementary plan goes into effect.

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

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time if program costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment

is open to him or who reenrolls after terminating his coverage would be increased by 10 percent for each full 12 months he stayed out of the program.

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

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

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

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

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

Under the House bill, the current provisions of law in the various public assistance titles of the act providing vendor medical assistance would have terminated upon the adoption of the new program by a State, but in no case later than June 30, 1967. The committee has amended this provision so that a State would have the option of continuing under the vendor medical provisions of existing law or adopting the new program.

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

The House bill requires that by July 1, 1967, under the new program a State must provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere) in order to receive Federal participation. The committee has altered this requirement so that it is more appropriate to the groups covered in that dental services are required for individuals under the age of 21 while skilled nursing home services are required for individuals 21 years of age or older. Coverage of other items of medical service would be optional with the States.

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

Standards as to quality of care and safety.—The committee added to the provisions of the House bill a requirement that the States include in their States plans descriptions of the medical staff utilized and the standards for institutions providing medical care and authorized the Secretary of Health, Education, and Welfare to promulgate minimum standards relating to fire and other hazards for such institutions.

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

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

Administration.—Under the House bill, the State agency administering the new program would have to be the same as that administering the old-age assistance program (i.e. the welfare agency). The committee, believing the States should be given more latitude in this matter, provided that any State agency may be designated to administer the program, as long as the determination of eligibility is accomplished by the agency administering the old-age assistance program.

Effective date.—January 1, 1966.

4. COST OF HEALTH CARE PLANS

Basic plan.—Benefits and administrative expenses under the basic plan would be about $1.1 billion for the 6-month period in 1966 and about $2.4 billion in 1967. Contribution income for those years would be about $1.5 and $2.8 billion, respectively. The costs for the uninsured (paid from general funds) would be about $285 million per year for early years.

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

If 80 percent of the eligible aged enrolled, benefit costs (and administrative expenses) of the supplementary plan would be about $665 million to $800 million in 1967 and about $910 million to $1.10 billion in 1968. Premium income from enrollees for those years would be about $555 and $565 million, respectively. The matching Government contribution would equal the premiums charged the individual.

If 95 percent of the eligible aged enrolled, benefit costs and administrative expenses of the supplementary plan would be about $790 to $945 million in 1967 and about $1.08 billion to $1.30 billion in 1968. Premium income from enrolles for those years would be about $660 million and $670 million, respectively. The Government contribution would equal the premiums charged the individual.

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

B. Child Health and Welfare Amendments

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

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

The authorizations for crippled children's service under the House bill would be increased by the same amounts. The committee has added a similiar increase in the authorization for the child welfare program.

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

Crippled children-training personnel.—The bill would also authorize $5 million for the fiscal year 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for

health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

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

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

The committee has added an amendment which has increased the authorization for such grants by $5 million for fiscal years 1968, 1969, and 1970 to cover the cost of special project grants to provide health services for school and preschool children who are or are in danger of becoming emotionally disturbed. Grants would be made to State or local health, mental health, or public welfare agencies, or other public or nonprofit private agencies or institutions. The committee amendment would further authorize an appropriation of $500,000 each for the fiscal years ending June 30, 1966, and June 30, 1967, for grants for studies of resources, methods and practices for prevention and diagnosis of emotional illness in children and for treatment and rehabilitation of emotionally ill children.

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

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

1. BENEFIT CHANGES

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

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

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of $44 (now $40) and to a new maximum

of $135.90 (now $127). In the future, creditable earnings under the increase in the contribution and benefit base to $6,600 a year (now $4,800) would make possible a maximum benefit of $168.00.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a $254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill the highest family maximum would be $368.00.

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

H.R. 6675 includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit until the child reaches age 22, provided the child is attending a public or an accredited school, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be eligible for benefits for September 1965, when the school year begins.

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

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

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

(*d*) *Amendment of disability program*

(*i*) *Definition of disability.*—The bill would eliminate the present requirement that a worker's disability must be expected to be of long continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been under a disability which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment. An estimated 60,000 persons—disabled workers and their dependents—will become immediately eligible for benefits as a result of this change.

(*ii*) *Disability benefits offset provision.*—The bill provides that the social security disability benefit for any month for which a worker is receiving a workmen's compensation benefit will be reduced to the extent that the total benefits payable to him and his dependents under both programs exceed 80 percent of his average monthly earnings prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in national average earnings levels. The offset provision will be applicable with respect to benefits payable

for months after December 1965 based on applications filed after December 1965.

(*iii*) *Benefits for children disabled before reaching age 22.*—The bill provides that a child who is disabled before reaching age 22 (rather than before age 18 as in present law) would be eligible for disabled child's benefits should his parent die, become disabled or retire. The mother of the child would also be eligible for benefits so long as she continued to have the child in her care. Effective as to benefits for the second month following the month of enactment, an estimated 20,000 persons—disabled children and their mothers—will become immediately eligible for benefits as a result of this change.

(*iv*) *Facilitating disability determinations.*—The bill authorizes the Secretary to make determinations of disability or cessation of disability where medical and other information supplied or designated by the individual, or evidence of remunerative work activities, indicate clearly that the individual is under a disability or that the disability has ceased.

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

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

(*vii*) *Allocation of contribution income between OASI and DI trust unds.*—Under the bill, an additional 0.2 percent of taxable wages and 0.15 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to 0.70 percent and 0.525 percent, respectively, beginning in 1966.

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

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

(*i*) *Men and women workers.*—Under the "transitional insured status" provision a worker could qualify for benefits at age 72 if he had one quarter of coverage for each year that elapsed after 1950 and up to the year in which he reached age 65 (62 for women), with a minimum of three quarters. Those quarters could have been acquired at any time since the inception of the program in 1937. Wives of workers who qualify under this provision would be eligible for benefits if they reached age 72 before 1969. For workers who reached age 65

(62 for women) after 1956, the quarters of coverage requirement merges with the present minimum requirement of six quarters.

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

Transitional insured status requirements with respect to workers benefits

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3.	73 or over	3.
75	4.	72	4.
74	5.	71 [1]	5.
73 or younger	6 or more.	70 or younger	6 or more.

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

(*ii*) *Widows.*—Any widow who attains age 71 in or before 1965, if her husband died or reached age 65 in 1954 or earlier, could get a widow's benefit when she is aged 72 or over if her husband had at least three quarters of coverage. Present law requires six quarters. If the husband of such a widow died or reached 65 in 1955, the requirement would be four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters or more, the same as present law.

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

The table below sets forth the requirements as to widows:

Transitional insured status requirements with respect to widow's benefits

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

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

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

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

(f) Retirement test

The bill would liberalize the retirement test provision in present law under which benefits are decreased in relation to a beneficiary's earnings over $1,200 in a year. Under existing law, the first $1,200 a year is fully exempted, and there is a $1 reduction in benefits for each $2 of annual earnings between $1,200 and $1,700 and for each $1 of earnings thereafter. Under the bill, the first $1,800 a year would be fully exempted and there would be a $1 reduction in benefits for each $2 of earnings between $1,800 and $3,000 and for each $1 of earnings thereafter. In addition, the amount of earnings a beneficiary may have in a month and get full benefits for that month regardless of his annual earnings would be raised from $100 to $150. These changes are effective for taxable years ending after 1965.

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

For 1966, an estimated 850,000 persons—workers and dependents—either will receive more benefits under these provisions than they would receive under present law, or will receive some benefits where they would receive no benefits under present law.

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

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

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

Under present law, a widow's and widower's benefits based on a deceased worker's social security earnings record generally stop when the survivor remarries, with the result that some widows who would like to remarry do not do so because if they did they would lose their social security benefits. The bill provides that benefits would be payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit would be equal to 50 percent of the primary insurance amount of the deceased spouse rather than 82½ percent of that amount, which is payable to widows and widowers who are not remarried.

(i) Adoption of child by retired worker

The bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that, where the child is adopted after the worker becomes entitled to an old-age benefit, (1) the child must be living with the

worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child must be receiving one-half of his support for the entire year before the worker's entitlement; and (3) the adoption must be completed within 2 years after the worker's entitlement.

(*j*) *Definition of child*

The bill provides that a child be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so. Under present law, whether a child meets the definition for the purpose of getting child's insurance benefits based on his father's earnings depends on the laws applied in determining the devolution of interstate personal property in the State in which the worker is domiciled. This provision would be effective for the second month after the month of enactment. It is estimated that 20,000 individuals (children and their mothers) will become immediately eligible for benefits under this provision.

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

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

(*b*) *Farmers*

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

(*c*) *Cash tips*

The bill provides that cash tips received by a worker would be covered as self-employment income. Effective as to taxable years beginning after December 31, 1965.

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

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

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

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

(*f*) *Nonprofit organizations*

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

(*g*) *District of Columbia employees*

The bill provides for social security coverage of certain employees of the District of Columbia (primarily substitute schoolteachers).

(*h*) *Ministers*

Social security credit could be obtained for the earnings of certain ministers which were reported but which cannot be credited under present law.

3. MISCELLANEOUS

(*a*) *Filing of proof*

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

(*b*) *Automatic recomputation of benefits*

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

(*c*) *Military wage credits*

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

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

The bill liberalizes the requirement in existing law that an application for monthly insurance benefits be valid for only 3 months after the date of filing, and for disability benefits 3 months before the beginning of the waiting period. The bill would allow an application to remain valid up until the time the Secretary makes a final decision on the application.

(*e*) *Overpayments and underpayments*

The bill would make changes in the provisions of law relating to overpayments and underpayments to facilitate the recovery of overpayments and to provide specific authority, lacking in present law, for the Secretary to settle all underpayments of benefits.

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

The bill would authorize the Secretary to make a temporary overpayment so as to permit a surviving spouse to cash a benefit check issued jointly to a husband and wife if one of them dies before the

check is negotiated; any overpayment resulting from the cashing of the joint check would be recovered.

(*g*) *Attorney's fees*

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

(*h*) *Tax on certain corporations*

The bill provides that when an employee works for a corporation which is a member of an affiliated group of corporations and is then transferred to another corporation which is a member of such group, the total employer social security tax payable by the two corporations for the years in which the employee is transferred will not exceed the amount that would be paid by a single corporation. (Under present law, such treatment is provided for the employee.)

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

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

4. FINANCING OF OASDI AMENDMENTS

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

The tax rate schedule under existing law and the revised schedule provided by the House-passed bill and by the committee's bill for the OASDI program follow:

Year	Contribution rates (in percent)					
	Employer and employee, each			Self-employed		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1965	3.625	3.625	3.625	5.4	5.4	5.4
1966–67	4.125	4.0	3.85	6.2	6.0	5.8
1968	4.625	4.0	3.85	6.9	6.0	5.8
1969–72	4.625	4.4	4.45	6.9	6.6	6.7
1973 and after	4.625	4.8	4.9	6.9	7.0	7.0

5. ADDITIONAL BENEFIT PAYMENTS IN FIRST FULL YEAR, 1966

[In millions]

Total	$2,620
7-percent benefit increase ($4 minimum in primary benefit)	1,470
Modification of earnings test	590
Reduced benefits for widows at age 60	165
Benefits to persons aged 72 and over with limited periods in OASDI employment	140
Modification of definition of disability	40
Improvements in benefits for children, total	215
Child's benefits to age 22 if in school	195
Benefits for children disabled after age 18 and before age 22	10
Broadened definition of child	10

D. Public Assistance Amendments

1. INCREASED ASSISTANCE PAYMENTS

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

Effective January 1, 1966. Cost: About $150 million a year.

2. TUBERCULAR AND MENTAL PATIENTS

The House bill removed the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The House bill requires as a condition of Federal participation in such payments to, or for, patients in mental and tuberculosis hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The committee has amended this provision so as to make the special provisions for Federal participation applicable solely to payments for aged persons in mental institutions. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

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

3. AID TO FAMILIES WITH DEPENDENT CHILDREN IN SCHOOL

The committee bill extends the optional provision of the States to continue making payments to dependent children who have attained age 18 but continue in school up to age 21. Present law calls for regular attendance at a high school or vocational school. The committee bill would extend this to attendance at a college or university.

Effective after enactment. Cost: Negligible.

4. PROTECTIVE PAYMENTS TO THIRD PERSONS

The House bill included a provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined adult program, title XVI) unable to manage their money because of physical or mental incapacity. The committee bill would extend the same provision for protective payments to the programs of aid to the blind and aid to the permanently and totally disabled.

Effective January 1, 1966.

5. INCOME EXEMPTIONS UNDER PUBLIC ASSISTANCE

(*a*) *Old-age assistance*

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

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

(*b*) *Aid to families with dependent children*

The committee has added an amendment which allows the State, at its option, to disregard up to $50 per month of earned income of any three dependent children under the age of 18 in the same home.

Effective July 1, 1965. Cost: $1.3 million for first full year of operation.

(*c*) *Aid to the permanently and totally disabled*

The committee bill adds an exemption of earnings, at the option of the State, for recipients of aid to the permanently and totally disabled. As in the case of the aged, the first $20 per month of earnings and one-half of the next $60 could be exempted. In addition, any additional income and resources could be exempted as part of an approved plan to achieve self-support during the time the recipient was undergoing vocational rehabilitation.

(*d*) *Old-age and survivors insurance (retroactive increase)*

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

(*e*) *Economic Opportunity Act earning exemption*

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

(*f*) *Income exempt under another assistance program*

The committee bill adds a provision that any amount of income which is disregarded in determining eligibility for a person under one of the public assistance programs shall not be considered in determining the eligibility of another individual under any other public assistance program.

6. DEFINITION OF MEDICAL ASSISTANCE FOR AGED

H.R. 6675 modifies the definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution.

Effective July 1, 1965. Cost: About $2 million.

7. JUDICIAL REVIEW OF STATE PLAN DENIALS

The House bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs or noncompliance with State plan conditions in the Federal law. The committee bill would add an amendment setting a time limit on the Secretary's calling of a hearing and substitutes language providing the more traditional terminology as to the "substantial evidence rule."

III. GENERAL DISCUSSION OF PROVISIONS SHOWING DIFFERENCE IN HOUSE BILL

A. Health Care

For almost 5 years this committee has given active consideration to ways of providing help for old people who need assistance in meeting medical costs. As may be recalled, in 1960 the 86th Congress, after very careful and exhaustive review of the situation and many proposed solutions, concluded that Federal legislation was necessary. The result was the formulation and enactment of the medical assistance for the aged program, more popularly referred to to as the Kerr-Mills program. At that time it was the view of the committee that such a program should be undertaken to determine whether it would or could adequately meet the national need. It has now been 5 years since enactment of the 1960 Social Security Amendments and there has been opportunity to evaluate the implementation of the medical assistance for the aged program and to formulate a judgment as to the extent to which this national problem is being met. Although the committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to provide coverage and services to the extent anticipated. The committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

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

The first of the two insurance programs consists of protection against the costs of hospital and related care. This hospital insurance plan would be financed through a new special tax separate from existing social security taxes; and the contributions collected would be kept entirely separate from the funds of the existing program in a new Federal hospital insurance trust fund. The proposed hospital insurance would be financed through the new tax contributions during the individual's working lifetime with benefits available at age 65.

In past amendments to the Social Security Act, when new programs have been developed or when significant changes have been made to

meet a national need, the Congress has followed the practice of extending the new or enhanced benefits not only to those who will become eligible for them in future years but also to the individuals then currently on the rolls. This has been done, of course, with the knowledge that the current beneficiaries on the rolls have not made contributions specifically for the increased benefits or the new benefits then being provided. Of course, this means that the benefits going to the already-retired group, represent in a sense an "unfunded" liability which has to be met out of future contributions. However, the practice has always been to cover the present beneficiaries. Basic to it is the recognition that the problem which such new legislation is designed to meet exists not only for those who will become eligible in the future but equally for present beneficiaries. It may be noted that the same practices are often followed under private pension plans; namely, to extend benefit liberalizations to existing pensioners on the rolls when doing so for future pensioners.

The second of the two insurance programs is a voluntary supplementary medical insurance plan that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program. At the beginning the voluntary supplementary plan would be financed through monthly premiums of $3, and through equal matching contributions from Federal Government general revenues. The combined coverage of the two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people can be expected to have the protection of both of these insurance programs.

The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. Further, the bill specifically provides that a beneficiary may obtain services from any participating institution, agency, or person who undertakes to provide him with the services. The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

In establishing the complementary plans for medical care for the aged in this bill, no special recognition is being given to the lower rate of hospital utilization which might be experienced by aged persons under comprehensive health care plans. However, it is not the intention of the committee by this action to adversely affect those organizations which provide and operate comprehensive health care services. On the other hand, it is the hope of the committee that the development of comprehensive health care plans be encouraged.

1. BASIC PLAN—HOSPITAL INSURANCE

(a) Eligibility for protection under the basic plan

The proposed basic hospital insurance would be provided (on the basis of a new section in title II of the act) for people aged 65 and over who are entitled to monthly social security benefits or to an-

nuities under the Railroad Retirement Act (the administration and financing of benefits for railroad retirement beneficiaries are discussed in sec. (e) p. 38). In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

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

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

[1] Same as OASI.

As indicated in the table, by 1974 the number of quarters of coverage required for cash benefits and hospitalization insurance benefits will be the same and the "transitional" provision will phase out for those reaching age 65 thereafter.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who have actual coverage under the provisions of the Federal Employees Health Benefits Act of 1959. The House bill would also have excluded individuals and their wives who had the opportunity to come under the Federal act but had not so elected. The committee did not believe that the exclusion of this group was equitable. It believes that actual coverage under the Federal employees program should be the sole basis for exclusion. Others excluded would be aliens who have not been residents of the United States for 10 consecutive years, aliens who have not been admitted for lawful residence, and persons convicted of certain subversive crimes.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will meet the insured-status requirements for the proposed hospital insurance.

(b) Benefits

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

(1) Inpatient hospital benefits

The proposed inpatient hospital benefits would, except for an initial deductible amount and a coinsurance feature for days in excess of 60, cover the cost of services provided by (or under arrangements with) participating hospitals for up to 120 days in any one "spell of illness." This is an expansion of the limit of 60 days in the House bill to recognize the need of those relatively few people who need protection for necessary stays of long duration. The imposition of the coinsurance after the 60th day is a safeguard against any possible abuse of hospital utilization in these cases. A spell of illness would normally begin with the day a beneficiary enters a hospital and end after the beneficiary has remained out of a hospital and out of an extended care facility for 60 consecutive days.

Inpatient services in psychiatric hospitals, which were included in the voluntary supplementary plan in the House bill, have been moved to the basic hospital plan under the committee's bill. Moreover, the lifetime maximum of 180 days of psychiatric hospital care under the House bill has been increased to 210 days. If a person is in a psychiatric or tuberculosis hospital at the time he becomes entitled to benefits, the days he has already been in the hospital would count toward the 120-day limit on coverage of care in such a hospital during a spell of illness. This provision is in keeping with the intent of the basic plan to cover only the active phase of treatment and not to cover 120 days of care for a person who may have been institutionalized for years previously.

The deductible amount applicable to inpatient hospital services at the beginning of the program would be $40 per spell of illness. The deductible would be changed thereafter, but not before 1969, to keep pace with increases in hospital costs. Each year, beginning in 1968, the Secretary would determine the amount of the deductible applicable for the succeeding year on the basis of the relationship between the average amount paid per day for inpatient hospital services during year preceding the determination and the rate for 1966. Increases in the deductible amount would be made in $4 steps so that changes of a few cents or even of a few dollars would not have to be made immediately following each such change. (The House bill provided $5 steps but the committee has altered this in the interest of administrative simplicity.) However, over a period of time these changes would accurately reflect the changes in hospital costs. Small annual changes would not only be an administrative problem, but they would also increase the problems of keeping beneficiaries informed of the applicable deductible. The coinsurance which is initially set at $10 a day (established by computing one-fourth of the inpatient hospital deductible) for days in excess of 60 would be increased in the same way

as the deductible amount if hospital costs increase. It, too, would remain static until 1969.

Covered services.—The reasonable cost of service ordinarily provided to inpatients by hospitals (other than certain other items discussed subsequently), including new services and techniques as they are adopted in the future, would be paid for. Services furnished to inpatients by others under arrangements with a hospital could also be covered if the arrangements call for billing for the services to be through the hospital exclusively. Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care. The following are the major items and services that would be paid for.

Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated—ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

Nursing services ordinarily furnished by hospitals would be paid for, but private duty nursing would not be covered.

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by medical and dental interns and residents in training under approved teaching programs. Dental interns in training was an addition by the committee bill. Under the House bill, the exclusion of physician's services would also have excluded the services of radiologists, anesthesiologists, pathologists, and physiatrists and they only would have been covered under the voluntary supplementary plan. The House bill, however, provided that the services of nonphysician technicians aiding such persons would be covered under the hospital insurance plan.

The committee believes that it is not wise to separate the billing for these medical specialities. Therefore, the committee bill provides that where the services in radiology, anesthesiology, pathology, and physiatry are arranged for and billed through a hospital they will be covered under the basic hospital insurance plan. Conversely, where the arrangement is that the specialist is not paid by or through the hospital, reimbursement for the services will be made under the voluntary supplementary plan.

Drugs and biologicals furnished to hospital patients for their use while inpatients would be paid for under the House bill. Payment would be provided for all drugs and biologicals which are listed in the United States Pharmacopoeia or National Formulary or New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing the drugs and biologicals. (These publications have been compiled and are maintained by the professional organizations concerned with the proper use of drugs.) The committee has added the United States Homeopathic Pharmacopoeia to the list of drug formularies to be

used and specifies that drugs approved for listing in the approved formularies, although not actually listed, would be included. The alternative requirement of approval by a committee of the medical staff of the hospital is in line with the recommendations of the American Hospital Association, American Medical Association, American Pharmaceutical Association, and the American Society of Hospital Pharmacists. These organizations jointly have recommended that hospitals adopt a formulary system based upon the functioning of a pharmacy and drugs therapeutics committee of the medical staff of the hospital as a means of protecting the hospital's patients against drugs of poor quality. Innovation and the use of new drugs would not be discouraged because such hospital committee could adopt for use any new drugs which it approved.

The committee did hear testimony that some of the drugs frequently administered in hospitals are combination drugs. While the principal ingredient of the combination drug may be listed in the formularies specified in the bill, the other ingredients, of secondary importance, are often not and, thus, the drug is excluded. The committee bill would provide for the inclusion of such a combination drug if the principal ingredient, or ingredients, are listed in an approved formulary.

The intent of the provisions for determining which drugs and biologicals are covered is to permit payment for all drugs and biologicals which medical and medically related organizations have evaluated and selected as being proper for use in the course of good patient care.

There will be a deductible in an amount equal to the cost of the first 3 pints of blood furnished for an individual during a spell of illness. The difference between the cost of the blood to the hospital and the charge to the beneficiary would be deducted from the payments the proposed program would otherwise make to the hospital. Thus the hospital would not make a profit on the blood for which it charges a beneficiary. The committee included this deduction provision in the interest of the voluntary blood replacement programs, which encourage donations of blood by waiving charges for blood which the patient arranges to replace. The limitation of the deduction to 3 pints of blood was made in view of the problems aged people would have in securing replacement of, or paying for, large quantities of blood.

Supplies and appliances would be paid for under the hospital insurance plan when they are a necessary part of the covered inpatient hospital services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital services but payment for hospital services would not cover furnishing these items to the patient for use after his discharge. (However, the cost of using these items after hospitalization might be paid for if needed as part of the posthospital extended care he might receive or it might be provided under a plan for his home health services.) Items supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program.

Conditions of participation.—The committee's bill lists conditions that hospitals must meet in order to participate in the proposed program. These conditions for participation are included to provide assurance that participating institutions are safe, that they have facilities and organization necessary for the provision of adequate care, and that they exercise their responsibility to discourage improper

and unnecessary utilization of their services and facilities. The inclusion of these conditions is designed to support the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, health insurance plans, and other interested parties to improve the quality of care in hospitals. To allow payments to institutions for services of lower quality than are now generally acceptable might reduce the incentive for establishing high-quality institutions or for maintaining high standards where they now exist.

In order to participate in the program, hospitals would be required to be licensed (of course, certification or approval where such procedures are State or local law equivalents to licensing would meet this requirement) and satisfy conditions specified in the bill relating to clinical records, medical staff bylaws, and utilization review. They would also have to meet certain other specified requirements. The bill authorizes the Secretary to prescribe such further requirements as the Secretary finds necessary in the interest of health and safety. The health and safety requirements prescribed by the Secretary (including any requirements requested by a State which are higher than those prescribed for other States), cannot, however, be more strict than the comparable conditions prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. Thus, the Secretary could, for example, require participating hospitals to maintain tissue committees which reexamine the condition of the organs removed during surgery and to meet other conditions which the health professions consider necessary to good patient care, but the Secretary could not set the hospital standards above the professionally established level.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the conditions for participation, except for the requirement of utilization review. (If the Joint Commission adopts a requirement for utilization review, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets all the requirements of the law.) Linking the conditions for participation to the requirements of the Joint Commission provides further assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

The conditions of participation for psychiatric and tuberculosis hospitals would be similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while paying for active treatment in psychiatric and tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a psychiatric and tuberculosis hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited.

The committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will go or be taken to a hospital that does not participate in the program. For example, an accident victim might have to be taken immediately to the nearest hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. The committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution. To be paid under the program for its services, the nonparticipating hospital, like participating hospitals, would have to agree not to charge the patient amounts (except the deductibles and coinsurance) in addition to the program's payments for covered services. The committee has added a provision for emergency services in a hospital outside the United States when it is closer or substantially more accessible than comparable facilities in the United States. A further qualification is that the patient has to be physically present within the United States when the emergency which necessitated the hospitalization occurred.

Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ, Scientist, in Boston, could participate in the program as "hospitals." The participation of these institutions and the payment for items and services furnished by them would be subject to such conditions, limitations, and requirements as may be provided in regulations. In general, however, the committee intends that payments to Christian Science sanatoriums would cover costs of services ordinarily furnished by these sanatoriums to patients which are comparable to those for which payment could be made to hospitals and intends these sanatorium services to be a substitute for, and not an addition to, medical services that might be furnished to a person if his religious beliefs were not contrary to the use of the usual facilities. Coverages and exclusions applicable to hospital care would also apply in these institutions. For example, the services of a Christian Science nurse would be covered unless her duties are those of a private duty nurse or attendant; similarly, the services of a Christian Science practitioner, who is the Christian Science counterpart of the physician, would not be paid for since physician's services are not paid for under the hospital insurance plan. Payment would only be made for bedfast patients who, except for their religion, would have to have been admitted to a hospital.

(2) Posthospital extended care benefits

Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.

The posthospital extended care benefits which would be provided under the hospital insurance plan would cover care in qualified extended care facilities in cases where the patient was hospitalized for 3 or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge. Under the House bill, a patient who meets the hospital-transfer requirement and who is then discharged from the extended facility to his home could again receive extended care benefits in the same spell of illness

without being hospitalized again if he is readmitted to the same facility within 14 days after discharge. The committee amended this provision so that the individual could be readmitted to any participating facility within 14 days. In some cases, there might not be an available bed in the original extended-care facility. The hospital-transfer requirement is intended to help limit the payment of the extended-care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following in-patient hospital care and makes less likely unduly long hospital stays. This requirement also helps to assure that before a patient is admitted to an extended care facility his medical condition and needs will have been adequately medically appraised. Immediate transfer from a hospital to a posthospital extended care facility is not required because, in some instances, care in such a facility might be found to be needed, for example, only after a trial at convalescent care at the patient's home proves unsuccessful. Similarly, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to a participating facility.

Payments could be made for up to 100 days of care in extended care facilities during any one spell of illness. The payments made for each day beyond the 20th day of the patient's stay in a facility would be reduced by a coinsurance amount paid by the patient equal to $5 a day, initially, computed on the basis of one-eighth of the deductible for in-patient hospital services. In later years it will increase in the same manner as the hospital coinsurance if costs increase.

The House bill provision allowing for the conversion of unused hospital days into extended care days has been eliminated. However, 100 days of extended care, regardless of the length of hospitalization, would be available under the committee bill as opposed to as few as 20 days under the House bill.

Covered services.—The program would cover the items and services generally furnished by posthospital extended care facilities. These include room and board in two- to four-bed accommodations, nursing care, physical, occupational and speech therapy, and such drugs as are ordinarily furnished by the facility to its in-patients. In addition, payment could be made for the medical services of interns and residents in training and other diagnostic and therapeutic services furnished in-patients of the extended care facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records. Payment would also be made for physical, occupational, and speech therapy furnished by a party other than the facility if furnished under arrangements which provide for payment for therapy to be made through the facility. In no case could payment be made for any service, drug or other item which could not be paid for under the hospital insurance program if furnished in a hospital. Neither could payment be made for services not generally provided by posthospital extended care facilities. For example, under this rule the use of an operating room would not be covered in the case of an extended care facility since operating rooms are not generally maintained as part of such facilities.

Conditions for participation.—A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section

of a facility another part of which might serve as an old-age home. To assure that there will be no unnecessary barriers to the transfer of patients between hospital and extended care facilities when the attending physician determines the transfer is medically appropriate, a participating facility would be required (except as noted in the next paragraph) to have an agreement with a hospital for the transfer of patients and interchange of medical records. The requirement for a transfer arrangement does not mean that a patient would have to be transferred between a hospital and extended care facility which have such an arrangement with each other in order to qualify for extended care benefits. A transfer arrangement with any hospital would qualify the facility so that a patient's posthospital extended care would be paid for if he was admitted from any hospital.

Where an extended-care facility has attempted, in good faith, to arrange a transfer agreement with nearby hospitals, but failed, the State agency could waive the requirement for a transfer agreement if the agency finds that the facility's participation is in the public interest and essential to assuring extended care to older people in the particular community.

Extended care facilities would also be required to satisfy a number of conditions necessary for an institutional setting in which high-quality convalescent and rehabilitation care can be furnished. These include conditions relating to the provision of around-the-clock nursing services with at least one registered nurse employed full time, the availability of a physician to handle emergencies, the maintenance of appropriate medical policies governing the facility's skilled nursing care and related services, methods and procedures for handling drugs, and utilization review. In addition to the conditions specified in the bill, the Secretary would be authorized to prescribe such further requirements to safeguard the health and safety of beneficiaries as he may find necessary.

The committee added to the House bill a provision under which Christian Science nursing homes operated, or listed and certified by the First Church of Christ, Scientist, in Boston, Mass., could participate in the program as extended care facilities. The participation of these institutions and the payment for items and services furnished by them would be subject to such conditions, limitations, and requirements as may be provided in regulations. It is expected that in formulating these regulations, the Secretary of Health, Education, and Welfare would take into account similar objectives to those of the parallel provisions for the coverage of Christian Science sanatorium services.

(3) Posthospital home health care benefits

Payments would be made for visiting nurse services and related home health services when furnished in accordance with a plan established and periodically reviewed by a physician. The proposed payments would be made only for a patient who is under the care of a physician and confined to his own home (except when he is taken elsewhere to receive services which cannot readily be supplied at home). Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel—such as nurses or physical therapists—would be assured.

Up to 175 visits by home health personnel would be paid for during a spell of illness and any subsequent period before a new spell of illness begins. Such visits would have to occur during a 1-year period following the patient's discharge from a hospital or extended care facility. The House bill provided 100 visits, but the committee believed that this alternative to costly institutional care should be extended to some degree. To be eligible for home health benefits, the beneficiary would have to have been an inpatient in a hospital for at least 3 days or in an extended care facility and a home health plan for his care would have to be developed by a physician and steps would have to be taken to implement the plan within 14 days after his discharge.

A "visit" would be defined in regulations. It is contemplated, for example, that ordinarily one visit would be charged each time home health personnel furnish a covered service to the patient. For instance, a visit would be charged each time a therapist would go to the patient's home to furnish speech therapy. If a beneficiary had a visit from a speech therapist and a visiting nurse in the same day, two visits would be charged. Similarly, if the patient were to be taken to a hospital to receive outpatient therapy that could not be furnished in his own home—hydrotherapy, for example—and also receive speech therapy and other services at the hospital in the course of the same visit, two or more visits might be charged.

Covered services.—The proposed posthospital home health payments would meet the cost of part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services furnished by visiting nurse agencies, hospital-based home health programs and similar agencies. More or less full-time nursing care would not be paid for under the home health benefits provision. Payments could be made for services furnished by other parties under arrangements with such agencies—the services of an independent physical therapist and interns and residents in training of an affiliated hospital, for example.

To the extent permitted in regulations, the part-time or intermittent services of a home health aide would also be covered. The duties of the home health aide which would be covered are comparable to those of a nurse's aide in the hospital who would have had training and experience that is not ordinarily possessed by lay people—for example, training and experience in giving bed baths to ill and bedfast patients. Often, the home health aide services are essential if the patient is to be cared for outside a hospital or nursing facility. Food service arrangements, such as those of meals-on-wheels programs, or the services of housekeepers would not be paid for under the home health provisions.

While the home health patient would have to be homebound to be eligible for benefits, provision is made for the payment for services furnished at a hospital or extended care facility or rehabilitation center which requires the use of equipment that cannot ordinarily be taken to the patient in his home. In some cases special transportation arrangements may have to be made to bring the homebound patient to the institution providing these special services. The transportation itself would not be paid for. If he is furnished other services at the hospital or facility at the same time, these too could be paid for, even though they are of a kind that could be furnished in the patient's

home. But such services would be covered only if they are furnished under arrangements which provide for billing through the home health agency. For example, if it is necessary, because of the size of the equipment involved, to take the patient to a hospital to give him physical therapy and while at the hospital he receives speech therapy, benefits could be paid for both services, but only if the home health agency takes responsibility for arranging and billing for all the services.

Conditions for participation.—The conditions for participation of home health agencies are designed primarily to assure that participating agencies are basically suppliers of health services. The proposal would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. It would also cover home health services provided by a community hospital. In order to participate, the home health agency or organization would, in addition to meeting certain other requirements, either have to be publicly owned or be a nonprofit organization exempt from Federal taxation, or it would have to be licensed and satisfy staffing requirements and other standards and conditions prescribed by regulation. It is the understanding of the committee that organizations providing organized home care on a profit basis are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet.

The committee added to the House bill a provision under which a Christian Science nursing service operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Mass., could participate in the program as a home health agency. Their participation and the payment for items and services furnished by them would, like payments for Christian Science sanatoriums and nursing homes, be subject to such conditions, limitations, and requirements as may be provided in regulations.

(4) Out-patient hospital diagnostic benefits

Finally, payment could be made for tests and related services—other than those performed by physicians—that are ordinarily furnished by a participating hospital to its outpatients for the purpose of diagnostic study. Payments could also be made for such service furnished by others under arrangements with the hospital that provide for the billing to be through the hospital. Where the services are furnished outside the hospital, they would have to be furnished in facilities operated by or under the supervision of the hospital or its organized medical staff. (Diagnostic tests performed in a physician's office would, like other physicians' services, generally be covered under the voluntary supplementary plan unless part of a routine physical checkup.)

A deductible amount equal to one-half the deductible amount applicable in the case of in-patient hospital services would be applied against payments for out-patient hospital diagnostic services furnished by the same hospital during a 20-day period. The deductible would be $20 initially (one-half of $40). It will rise in the same manner as the hospital deductible if hospital costs rise in future years.

The committee was concerned that, under the House bill, there would be differences in the extent to which the patient's expenses

for diagnostic services would be reimbursed depending on whether the services were rendered in an out-patient section of a hospital and covered under the hospital insurance plan or furnished in a physician's office and reimbursed under the supplementary plan. The $20 deductible amount under the hospital insurance plan in some cases creates a financial incentive for a beneficiary to obtain diagnostic services in a physician's office—in cases where, for example, such services would not be subject to any deductible because the individual has already satisfied the $50 deductible requirement under the supplementary plan; in other cases, the incentive could be in the direction of using hospital facilities.

The committee's bill would minimize the differences in reimbursement in these cases by providing for payment of 80 percent, rather than 100 percent, of the cost (above the deductible) of out-patient hospital diagnostic studies and by counting amounts paid toward the out-patient deductible under the basic plan as an incurred expense under the supplementary plan. The House bill would, also, have allowed the crediting of the out-patient diagnostic deductible against the in-patient hospital deductible under certain circumstances. This provision has been eliminated in the committee bill.

(c) *Method of payment*

The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of the services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill. The regulations may provide for payment of the costs of services on a per diem, per unit, per capita, or other basis, may provide for the use of estimates in different circumstances, may provide for the use of estimates of cost of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost.

The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage should be taken of the experience of private agencies in order that rates of payment to hospitals may be fair both to the institutions, to the contributors to the hospital insurance trust fund, and to other patients. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Similar principles can without undue difficulty be developed to establish fair basis of payment to extended care facilities and home health services agencies.

The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of the services of other providers. The provision in the bill for payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to

another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program. The basis for the computation of the cost of beneficiaries may vary by institution. The most usual hospital cost reimbursement procedures now in use by plans that pay for in-patient services are based on the average per diem cost of the patients in the institution to which payment is made, adjusted to reflect the provisions of the plan. Some institutions, however, base their charges to the public on careful cost ascertainment or accounting and change their charges only when there is a change in the cost of the service involved. In these and other appropriate cases reimbursement would be permitted on the basis of the ratio of cost to charges for the services actually received.

In other institutions some of the charges are set according to prevailing rates in the area, or are based on other considerations and not solely on the actual costs of the particular items and services rendered. Except where a close correlation of cost and charges would be shown, other methods would have to be applied to achieve equitable reimbursement.

The concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of service, insuring organizations, and State and Federal governmental programs.

In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness.

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research.

In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a

share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible and coinsurance, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require, under the medical assistance and maternal and child health and crippled children programs of the Social Security Act, the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing income deficits arising out of providing hospital care to persons unable to pay for care.

These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.

In paying reasonable costs it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

(d) Financing

The hospital insurance program would be financed through a separate payroll tax that would be paid by employees, employers, and the self-employed, except as to railroad retirement eligibles whose benefit financing is discussed elsewhere. The proceeds of this tax would be earmarked to a newly established hospital insurance trust fund, which means that these funds will be kept completely separate from the taxes which support the present social security program. The earnings base of the new tax would be the same base as that for the social security tax so that the recordkeeping tasks of employers and the Government would be left largely unaffected by the establishment of a separate contribution for hospital insurance. To assure that the hospital insurance contributions are clearly identified as such to contributors, the bill requires that the withholding forms, W–2's, show what percentage of the worker's total tax payment was withheld to finance the cost of the proposed hospital insurance. Hospital insurance benefits and administrative expenses would be paid only from the hospital insurance trust fund.

The complete separation of hospital insurance financing and benefit payments is intended to assure that the hospital insurance program will in no way impinge upon the financial soundness of the old-age, survivors, and disability insurance trust funds. A separate annual report will be required on the operation of the hospital insurance pro-

gram. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsiblity for the benefits provided.

Under the proposed schedule of contribution rates, the fund would be sufficient to cover all the costs of the hospital insurance benefits (and administration) for persons entitled to social security or railroad retirement benefits. The schedule of contribution rates is the same for employers, employees, and self-employed persons and is as follows:

	Percent		*Percent*
1966	0.325	1976–79	0.65
1967–70	.50	1980–86	.75
1971–72	.55	1987 and after	.85
1973–75	.60		

As will be explained in greater detail later in this report, the schedule of contribution rates is based on conservative estimates of cost. The cost estimates also use the assumption that, while earnings will continue to rise in the future as they have in the past, the annual limitation on taxable earnings will not be increased beyond the increase provided for in the committee's bill ($6,600).

The cost of providing hospital and related posthospital insurance benefits to people who are not social security or railroad retirement beneficiaries would be met from general revenues.

(*e*) *Coverage of railroad workers*

The committee has added provisions to the bill which, subject to amending the Railroad Retirement Tax Act to establish a wage base which would finance the hospital benefits in a reasonably adequate manner, would make changes in the administration of hospital insurance benefits as to beneficiaries under the railroad retirement program. This amendment was suggested in a letter to the chairman of the committee from the chairman of the Committee on Labor and Public Welfare who said he had been advised by the chairman of the Railroad Retirement Subcommittee that such an amendment of the House bill "would correct an unwarranted departure from the agreement of long standing between the Secretary of Health, Education, and Welfare and the Railroad Retirement Board, and unwarranted departure from the congressional policy of long standing to conver upon the Railroad Retirement Board jurisdiction for the administration by the Board of all types of benefit programs for railroad employees, their dependents and survivors."

The House bill provides that the hospital insurance taxes imposed under the Federal Insurance Contributions Act (which applies to earnings covered under social security) would be imposed on railroad workers and employers in the same amount and in the same manner as hospital insurance taxes on workers and employers covered under social security.

Under the committee amendment, the taxes of the hospital insurance benefits program would be levied under the Railroad Reitrement Tax Act, with increases in the schedule of railroad retirement tax rates equal to the tax rates of the hospital insurance benefits program. Through the operation of the financial interchange provisions, the hospital insurance system would receive income from the railroad retirement account equal to the amount of the hospital insurance taxes on railroad employment which would be payable if such employ-

ment were covered directly under the hospital insurance system (as in the House bill) and would reimburse the account for the hospital insurance benefits paid from the account. If railroad retirement employment had been covered directly, the hospital insurance system would have paid such benefits with respect to people receiving railroad retirement benefits. The application of the financial interchange to hospital insurance benefits would be an extension of the financial interchange provisions which now apply to old-age, survivors, and disability insurance benefits.

The committee amendment also authorizes the Railroad Retirement Board to enter into agreements with Canadian hospitals and with hospitals devoted primarily to railroad employees, for the purpose of providing hospital insurance benefits for railroad retirement beneficiaries.

These amendments to the railroad retirement provisions of the bill would become effective only after the enactment of amendments to the Railroad Retirement Tax Act increasing the maximum amount of monthly compensation taxable under that act to an amount equal to or in excess of the one-twelfth of the maximum annual earnings creditable under the hospital insurance program. (Under present law the maximum amount of earnings taxable under the railroad retirement program is $450 a month; under the bill, the maximum annual earnings creditable under the social security and hospital insurance programs would be $6,600—$550 a month.) The amendments would become effective January 1, 1966, if the above-mentioned increase in the monthly compensation creditable under the railroad retirement program is in effect at the time and had been enacted by October 1965, or would become effective on January 1 of any subsequent year if the increase was in effect on October 1 of the immediately preceding year. If these financing conditions are not met, the financing and administration provided in the House bill will be in effect.

Under the financial interchange provisions discussed above the amounts of taxes which the railroad retirement account will have to transfer to the hospital insurance trust funds will be based upon the $6,600 social security tax base provided in the committee's bill. Making the amendments to the railroad retirement provisions of the bill contingent upon the railroad retirement tax base being made comparable to the hospital insurance tax base assures, on the whole, that the funds which are to be transferred to the hospital insurance trust funds under the financial interchange provisions will be obtained under the proposed increase in the railroad retirement contribution schedule.

2. VOLUNTARY SUPPLEMENTARY PLAN

(a) Eligibility and enrollment under the voluntary supplementary plan

The proposed supplementary insurance would be available to all people age 65 and over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either are citizens or aliens admitted for permanent residence who have had 10 years of continuous residence. Enrollment in the supplementary plan would be on a voluntary basis.

Under the committee-approved bill, the term supplementary medical insurance, rather than supplementary health insurance, is used

in order to more precisely characterize the benefits under the supplementary plan as being primarily coverage of the costs of physicians' services. The committee-approved bill would also advance the effective date in the House-passed bill for the supplementary plan by 6 months—from July 1, 1966, to January 1, 1967—in order to allow additional time for preparing to administer this program.

In general for a person attaining age 65 in the future, an eligible person could enroll during the period beginning with the third month preceding the month in which he attains age 65 and ending 7 months later. Under the House bill, the supplementary insurance would be effective with the first day of the third month following the month in which he enrolls (but not earlier than the effective date for benefit payments under the program). The committee bill modifies this provision so that the insurance coverage would begin more promptly provided the beneficiary subscribes without undue delay beyond the point at which he was first eligible. The insurance would take effect with the month the individual attains age 65 if he enrolls before that month. If he enrolls in the month in which he attains age 65, the insurance would take effect with the following month; if he enrolls the month following the month in which he attains age 65, it would take effect with the second month following the month of enrollment; if he enrolls more than 1 month following the month in which he attains age 65, the insurance would take effect with the third month following the month in which he enrolls.

A special enrollment period would be available at the beginning of the program for people who have already reached 65 by June 30, 1966. Under the committee bill this enrollment period would begin on April 1, 1966 and end on September 30, 1966. Coverage under the supplementary insurance for people who enroll during this period would begin with January 1, 1967. Individuals who are eligible to enroll during this initial general enrollment period but fail to do so could enroll at any time before April 1, 1967, if the Secretary determines that there was good cause for the individual's failure to enroll. However, if an individual enrolls under the latter provision, his coverage could not begin until the sixth month after he enrolls. Monthly premiums would be collected in advance for each month during which an individual was covered under the program.

There would be a general enrollment period between October 1 and December 31 of 1968 and during the comparable period in every even-numbered year thereafter. A person who enrolls in a general enrollment period would get protection effective with the July 1 following the general enrollment period.

No one could enroll for the first time more than 3 years after the close of the first enrollment period open to him and no one could reenroll unless he does so in a general enrollment period which begins within 3 years of the date his previous enrollment was terminated. A person could reenroll only once.

The limitations on enrollment and reenrollment such as those recommended are made in order to reduce the possibility of people enrolling in the program when their health deteriorates, thus increasing costs by covering people during periods of ill health who chose not to be covered during periods of good health.

The Secretary also is authorized to enter into an agreement with any State which, before January 1, 1968, elects to have certain of its money

payment public recipients covered by the supplementary plan. States would be permitted to decide whether to request enrollment of the money payment recipients of old age assistance or such recipients who are 65 years of age and older who are receiving money payments under the combined program, title XVI, or to decide to request coverage for all the aged among the money payment recipients under title I, IV, X, XIV, and XVI. Excluded from coverage under this arrangement are those persons who are entitled to receive a benefit under the old-age, survivors, and disability insurance system, or the Railroad Retirement Act. The State would pay, in behalf of each individual who is to be enrolled, the premium charge that is determined by the provisions of the bill. Those recipients of public assistance money payments who become 65 years of age on or after January 1, 1968, and who are eligible to enroll individually may have their monthly premium charges paid by the public assistance agency with Federal financial participation. However, the committee believes that it is not practicable at this time to authorize States to cover recipients of medical assistance for the aged through vendor payments under an agreement or to make premium payments in their behalf.

The bill provides that under certain circumstances, the State public welfare agency may act as the carrier in the State for the administration of those provisions with respect to individuals who are receiving money payments under public assistance programs, whether such individuals are covered by the agreement or not.

The agreement may also include provisions for transfer of public assistance funds to another carrier, if the State is not serving as a carrier, so that the insurance benefits and deductibles, coinsurance, and other items met by the State under its public assistance plans can be merged for purposes of paying providers of medical care.

(*b*) *Benefits under the voluntary supplementary plan*

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It would cover physicians' services, additional home health visits, and a variety of other health services, not covered under the hospital insurance plan. The beneficiary would pay the first $50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with normally 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

(1) Medical and other health services. These would include:

(*a*) Physicians' services, including surgery, consultation, and home, office, and institutional calls;

(*b*) Chiropractors' services and podiatrists' services;

(*c*) Services and supplies of the kind which are incidental to physicians' services furnished in their offices or hospital out-patient departments;

(*d*) Diagnostic X-ray and laboratory tests and other diagnostic tests;

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

(*f*) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;

(*g*) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;

(*h*) Prosthetic devices (other than dental) which replace all or part of an internal body organ;

(*i*) Ambulance services with limitations;

(*j*) Braces and artificial legs, arms, and eyes.

(2) Home health services for up to 100 visits during a calendar year (without a requirement of prior hospitalization).

The committee bill includes physicians' services within the definition of medical and other health services, rather than listing them separately as the House bill does and adds coverage of the services of chiropractors and podiatrists. Under the committee bill, physicians' services would include certain services performed by a doctor of dentistry or of dental or oral surgery, which would not be included under the House bill. Only surgery related to the jaw or a contiguous structure, and the reduction of fractures of the jaw or facial bones would be covered under this change made by the committee so that the cost of surgical services which may alternately be performed by a qualified physician or dentist would be covered whether a member of either profession performed the service. The committee bill also makes it clear that items, supplies, services of aids, etc., that are incidental to physicians' personal services would be covered in the hospital, clinic, home, or office and regardless of whether the bills are rendered by the hospital, the physician, or both. For example, the change would make it clear that a laboratory test would be covered whether performed in the physician's office or whether the physician sends the specimen to an independent laboratory and regardless of whether the physician or the laboratory bills the patient. If the test is performed in an independent laboratory, standards contained in the committee bill, which are described below, relating to laboratory services of independent laboratories would apply.

As mentioned previously, under the committee bill, in-patient psychiatric hospital services would be transferred to the basic plan rather than being under the supplementary plan as in the House bill.

The $50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills. As mentioned previously, under the committee-approved bill the out-patient hospital diagnostic deductible under the basic plan would be regarded as an incurred expense for purposes of the supplementary plan—i.e., it would count toward satisfying the $50 deductible and, where the $50 deductible has been met, it would count as an expense for which the supplementary plan would make payment. In this way out-patient hospital services and other out-patient services would be covered on a comparable basis.

There would be a special limitation on benefits for expenses in connection with treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital in-patient. During any year,

a maximum of $312.50 or 62½ percent of the expenses involved, whichever is smaller, would be considered incurred expenses—that is, expenses used in calculating benefit payments. The effect of this provision is to limit payment under the plan to a maximum of $250 (80 percent of $312.50) or half of the incurred expense (80 percent of 62½ percent of the expense), whichever is less.

Ambulance services would be covered only where other methods of transportation are not feasible due to the individual's condition, and only to the extent provided in regulations. It is the intention of the committee that transportation by ambulance be covered only if (*a*) normal transportation would endanger the health of the patient and (*b*) the individual is transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, to the patient's home or to an extended care facility.

Covered home health services and the conditions of participation for home health agencies would be the same as under the hospital insurance plan. There would, however, be no requirement, as there is in the hospital insurance plan, that benefits be paid only when the patient was previously hospitalized.

Under the committee bill, diagnostic tests performed in a laboratory which is independent of a physician's office or a hospital would be covered under the supplementary plan only if the laboratory is licensed under applicable State or local law or meets standards for such licensing and if it meets such other health and safety requirements as the Secretary finds necessary. The laboratory a physician maintains for performing diagnostic tests in connection with his own practice would be exempt from these standards but if the phyisician runs a laboratory which performs diagnostic work referred by other physicians the laboratory would be subject to these standards. The committee believes these requirements, which are not included in the House bill, are necessary to assure that only laboratory services of acceptable quality are paid for under the program.

(*c*) *Method of payment under the voluntary supplementary plan*

Under both the House bill and the committee bill, after the individual has incurred the $50 deductible amount, the plan would pay 80 percent of the reasonable costs of or the reasonable charges for the covered services. In the case of services furnished by, or under arrangements made by, hospitals, extended care facilities, and home health agencies, payment would be 80 percent of reasonable costs and would be made to the provider of services by the carrier administering the benefits under the supplementary plan.

In all other cases, except in the case of certain group practice plans, payment would be 80 percent of reasonable charges and would be made by the carrier to the beneficiary unless the beneficiary assigned the benefits to the person or organization which furnished the covered services. The committee bill would provide group-practice prepayment plans with the alternative of having the program pay 80 percent of the reasonable cost of the covered services they furnish (including physicians' services) rather than 80 percent of the reasonable charges. The committee believes this change is desirable to accommodate group-practice prepayment plans. Under such plans there is usually

no charge for a specific service, the physician being paid by the plan on a salary or other basis unrelated to reimbursement for a specific service. Among the bases permitted for reasonable cost determination is the calculation of costs on a per capita basis—the one which the group-practice prepayment plans generally use for their members.

Reasonable cost, as defined for purposes of reimbursement under the supplementary plan, would be the same as under the hospital insurance plan. The carriers administering the benefits under the supplementary plan would, under the terms of their contracts with the Secretary, have to take such action as may be necessary to assure that where payment is on a cost basis, the cost is reasonable cost. In general, under the supplementary plan a provider of services (a covered hospital, extended care facility, or home health agency) could charge a beneficiary the $50 deductible and 20 percent of the reasonable charges (in excess of the $50 deductible) for the covered services.

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment, the reasonable charge would have to be accepted as the full payment. The Committee has inserted into the bill the House report language that, in determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

The committee believes that the use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. For example, procedures established by State or local medical societies for resolving fee disputes are regularly utilized by carriers. Such arrangements could be used not only to settle questions between carriers and physicians but also between patients and physicians when the patient believes that an incorrect charge has been made. Also, the use of relative value scales, where they have been agreed upon, is helpful in establishing a reasonable relationship between payments for various medical procedures. And, where service benefit plans, for payment for physicians' services, serve as carriers under the program, the use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees.

(*d*) *Financing*

Both the House bill and the committee bill establishes a premium of $3 a month initially for individuals who enroll under the supplementary plan. Since the minimum increase in cash social security benefits provided under the bill for retired workers 65 and over would be $4 a month ($6 a month for man and wife who are both 65 and are receiving benefits based on the same earnings record), the minimum benefit increase would fully cover the amount of monthly premiums for the

supplementary plan. Under the House bill, persons enrolling who are entitled to monthly social security or railroad retirement benefits would have the premiums deducted from their monthly benefits. The committee-approved bill adds a similar provision for withholding the premiums of an enrolled individual from the annuity he receives under the civil service retirement system or another retirement system administered by the Civil Service Commission. If the wife of such an individual is also enrolled, and he agrees, her premium may also be withheld from his monthly annuity. (Of course, in any case enrollment in the plan is voluntary.) Deducting the premium from monthly benefits would help keep collection costs to a minimum. The method of collecting premiums for those who are not entitled to monthly benefits would be prescribed by the Secretary. People who are entitled to monthly benefits but who, because they have not retired, may not actually receive them or those who may receive only a part of them could estimate the amount by which premiums will exceed the amount of their benefits and could pay in advance the required additional amount to the Secretary. If advance payment is not made in these cases, the Secretary would specify the payment procedure. It is expected that the annual calculation of adjustment in benefits needed where a beneficiary has worked in the prior year would take into account the premiums owed and paid in connection with the supplementary plan.

Provision is made for the Secretary to adjust the premium amounts supporting the program if medical or other costs rise, but there would be no increase in premiums before 1968, and increases would be made not more often than every 2 years after 1968. To take into account the higher cost of insuring an older individual, premiums payable by a person who enrolled later than the first period when enrollment was open to him or who reenrolled after his enrollment was terminated would be increased by 10 percent for each full year he could have been but was not enrolled.

There would be a contribution from Federal general revenues equal to the aggregate premiums payable by enrollees. In addition, under the House-passed bill, funds could be appropriated in fiscal year 1966 and remain available through the next fiscal year as repayable advances (without interest) to the trust fund in order to provide an operating fund at the beginning of the program and to provide a contingency reserve. The committee-approved bill modifies this provision, to take account of the later effective date of the supplementary plan and to provide greater flexibility as to the time of the appropriation. The appropriation would be available through the calendar year 1968. The amount that would be appropriated for this purpose would be $18 per person eligible to enroll at the beginning of the supplementary program, January 1, 1967.

A new separate trust fund would be established—the Federal supplementary medical insurance trust fund. All premiums and Government contributions for the supplementary program would be paid into the fund and all benefits and administrative expenses would be paid from the fund.

3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

(a) *Conditions and limitations on payment for services*

(1) *Physicians' role*

The committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

In the case of in-patient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that in-patient diagnostic study was medically required and that the services were necessary for such purpose. The first physician recertification in each case of in-patient hospital services furnished over a period of time would be required no later than the 20th day of the period. In the case of out-patient hospital diagnostic services, a physician would have to certify that the services were required for diagnostic study.

In the case of posthospital extended care a physician would have to certify that the care was required because the individual needed ski led nursing care on a continuing basis for a condition with respect to which he was receiving in-patient hospital services prior to transfer to the extended care facility or for a condition which arose after such transfer and while the individual was still in the facility for treatment of the condition or conditions for which he was receiving such in-patient hospital services.

In the case of home health services, a physician would have to certify that the services were required because the individual was confined to his home. He would also have to certify that the individual needed (except for receipt of special treatment at a medical institution) skilled nursing care on an intermittent basis or physical or speech therapy. In the case of home health services, the intermittent nursing care or the physical or speech therapy would have to be for treatment of a condition for which the individual had received in-patient hospital services or posthospital extended care.

The committee recognizes that there often is a significant difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care in such institutions is purely custodial, and it is the intent of the bill to cover only active care intended to cure patients in such hospitals and not to cover cutodial care. Therefore, the bill would require that a physician make specific certifications before payment could be made for in-patient hospital services furnished in either a psychiatric hospital or a tuberculosis hospital. In the case of in-patient hospital services furnished in a psychiatric hospital for the psychiatric treatment of an

individual, a physician would have to certify that the psychiatric services could reasonably be expected to improve the condition for which the treatment was necessary or that in-patient diagnostic study was medically required and in-patient psychiatric hospital services were necessary for such purposes. In the case of in-patient tuberculosis hospital services a physician would have to certify that the services were required to be given on an in-patient basis for the treatment of an individual for tuberculosis and that the treatment could reasonably be expected to either improve the condition for which the treatment was necessary or render the condition noncommunicable.

(2) Utilization review

The committee is particularly concerned that the utilization and review function is carried out in a manner which protects the patients while at the same time making certain that they remain in the hospital only so long as is necessary, and that every effort be made to move them from the hospital to other facilities which can provide less expensive, but equal, care to meet their current medical needs.
pay its benefits in full. The committee expects that the patient's

The provisions of the committee's bill with respect to mechanisms for the review of utilization of services follow the kind of recommendations for utilization review that have been made by private study groups, State and National medical societies, and State agencies.

Hospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan providing for a review of admissions to the institution, length of stays, and the medical necessity for services provided with the objective of promoting the efficient use of services and facilities. The review would ordinarily be carried out by a staff committee of the institution, which would have to include two or more physicians but which could also include other professional personnel such as registered nurses and medical social workers. Alternatively, the review could be conducted by a similar group outside the institution—preferably one established by the local medical society and some or all of the hospitals and extended care facilities in the locality. In some circumstances the review committee would have to be one outside the institution—for example, where the small size of the institution or, in the case of an extended care facility, the lack of an organized medical staff makes it impracticable for the institution to have a properly functioning staff committee. As mentioned previously, if and when the Joint Commission on the Accreditation of Hospitals adopts a utilization review requirement for accreditation, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets the requirements of the law.

Under a utilization review plan, timely review would have to be made of each case in which a beneficiary stays in the institution for an extended period. Regulations would provide the institution some leeway in determining when the review would have to be carried out, and the point at which a review would be most appropriate might vary with the diagnosis and treatment involved. Where timely reviews are not being made, the Secretary could, in lieu of terminating the agreement under which the institution participates in the program, make a decision that with respect to that institution the program would make payment only for the first 20 days of a beneficiary's stay in the case of

a hospital, or only for days up to a specified number (to be specified in regulations) in the case of an extended care facility.

The attending physician would have to be offered an opportunity for consultation before there could be a finding that a beneficiary's further stay in the institution is not medically necessary, by the physician members of the review group; and the individual, the institution and the attending physician would have to be promptly notified of any such finding. Where such a finding has been made, the program could not make payment for services furnished the patient after the third day following the day on which the institution received notice of the finding.

Under the committee's bill, various organizations participating in the administration of the program could have a role in facilitating utilization review. State agencies could provide consultative services to assist in the establishment of utilization review procedures and in evaluating their effectiveness. Under the hospital insurance plan, public or private organizations nominated by providers must assist in the application of safeguards against unnecessary utilization. Carriers administering benefits under the voluntary supplementary plan would determine compliance with the utilization review requirement; assist in the establishment of review groups outside hospitals; assist hospitals, extended care facilities and others who furnish covered services to develop procedures relating to utilization practices; and make studies of such procedures and methods for their improvement.

(*b*) *Exclusions from coverage*

The committee's bill would exclude certain health items and services from coverage under both the hospital insurance and the voluntary supplementary medical insurance programs in addition to any excluded through the operation of other provisions of the bill. For example, the bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. Thus, payment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. Similarly, such potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.

The proposed insurance programs would not pay for any item or service furnished an individual if neither the individual nor any other person (such as a prepayment plan) has a legal obligation to pay for or provide the services. (Under the provision, the third-party liability statute 42 U.S.C. 2651–2653 would not apply.) Free chest X-rays provided by health organizations, for example, would not be covered. Where health expenses are charged the patient by a member of the patient's household or by an immediate relative, no payment would be made. However, a person of little means would not be barred from payment under the insurance programs because he met the test of medical indigency and was otherwise eligible to receive medical assistance under a public assistance program. Furthermore, if a person received his care on some prearranged basis toward which he

prepaid, the program provided for under the title would nevertheless pay its benefits in full. The committee expects that the patient's prepayment arrangement would be adjusted appropriately in consideration of the fact that the program met part of the patient's health costs. Under the House-passed bill, except in such cases as the Secretary may specify, no payment would be made for items and services which are paid for directly or indirectly by a governmental entity. The committee-approved bill modifies this provision to make it clear that no person would be denied benefits because he was also covered under a State or local government employee health benefits plan.

Payments would only be made for items and services provided in the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Payment would not be made for items and services required as a result of war or an act of war which occurs after the effective date of the individual's coverage under the proposed program.

Payments would not be made for routine physical examinations or for eyeglasses, hearing aids, or the fitting expenses or other costs incurred in connection with their purchase. The committee bill provides a specific exclusion of routine dental care to make clear that the services of dental surgeons covered under the bill are restricted to complex surgical procedures. Thus, payment would be made under the supplementary plan for the physician's services connected with the diagnosis of a specific complaint and the treatment of the ailment, but a routine annual or semiannual checkup would not be covered. Similarly, the diagnosis and treatment by an ophthalmologist of, say, cataracts would be covered but the expenses of an eye examination to determine the need for eyeglasses and charges for prescribing and fitting eyeglasses or contact lenses would not be covered. Similarly, too, routine dental treatment—filling, removal, or replacement of teeth or treatment of structures directly supporting teeth—would not be covered. Neither would payment be made for orthopedic shoes or other supportive devices for the feet.

Expenses for cosmetic surgery would not be covered except where incurred in connection with the prompt repair of an accidental injury or to improve the functioning of a malformed body member. For example, cosmetic surgery could be paid for when furnished in connection with the treatment of a severely burned person.

Payment would not be made for health items and services to the extent that payments have been made, or can reasonably be expected to be made, for them under a workmen's compensation law. The Secretary would prescribe regulations to govern the making of payments where a beneficiary's status under workmen's compensation has not been ascertained. Payment would be made under the insurance plans on the condition that repayment would be made if information is received that a workmen's compensation payment for the health care has been made.

(c) *Administration of health insurance provisions*

Overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs would rest with the Secretary of Health, Education, and Welfare, but State agencies and private organizations operating under agreements with

the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role. In addition to using such organizations under the conditions described below, the Secretary would be authorized to purchase or contract separately for services such as auditing or cost analysis.

(1) Advisory and review groups

The committee's bill provides for the establishment of a Health Insurance Benefits Advisory Council to advise the Secretary on general administrative policy matters and on the formulation of regulations in connection with the hospital insurance program and supplementary medical insurance program, including regulations relating to conditions of participation for providers. The Advisory Council, appointed by the Secretary, would consist of a chairman and 15 members including persons outstanding in hospital, medical, and other health activities and at least one representative of the public. The members could not include regular Federal Government employees.

The bill also provides for the establishment of a National Medical Review Committee to study the utilization of hospital and other medical care and services with a view to recommending changes in the way covered care and services are used and in the administration of the basic and supplemental plans.

The committee is required to make an annual report of its recommendations to the Secretary, and he is required to transmit the report to the Congress.

The committee is to be composed of nine persons, one of whom the Secretary would designate as chairman. The members are to be selected from people who are representative of organizations and associations of professional people in the field of medicine and other people who are outstanding in the field of medicine or related fields and a majority of the committee are to be physicians and at least one member will represent the general public. Regular Federal Government employees could not be members of the committee.

(2) Conditions of participation

In formulating specific conditions of participation necessary for health and safety, the Secretary would consult with appropriate governmental agencies and private organizations. The bill specifically requires consultation with appropriate State and local agencies and national listing or accrediting bodies. The committee would expect that the Secretary would consult with the Joint Commission on the Accreditation of Hospitals as well as with associations of providers of services. Such consultations should be helpful in the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the basic and supplementary plans. Such consultation would provide additional assurance that varying conditions of local and national significance are taken into account.

(3) Agreements to participate

An eligible hospital, extended care facility, or home health agency could participate in the programs if it filed with the Secretary an agreement not to charge any beneficiary for covered services for which payment would be made under the program and to make adequate provision for refund or erroneous charges. Of course, a provider could

bill a beneficiary for deductible and coinsurance amounts, for the first 3 pints of blood furnished him during a spell of illness, and for the portion of the charge for a private room or services supplied at the patient's request and not paid for under the program.

An agreement could be terminated by either the provider of services of the Secretary of Health, Education, and Welfare. Beneficiaries would be protected from an abrupt termination of an agreement by a provider by the requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective may be specified in regulations (but the length of time cannot be longer than 6 months).

The Secretary could terminate an agreement only after reasonable notice and only if the provider (*a*) does not comply with the provisions of the agreement or of the law and regulations, (*b*) is no longer eligible to participate, or (*c*) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary would be required to give reasonable notice and opportunity for hearing to a provider of services before making a final determination that the provider does not qualify to participate under the program or before terminating an agreement with the provider. The final administrative decision is subject to judicial review.

(*4*) *Role of the States*

The committee's bill provides for State agencies, operating under an agreement with the Secretary, to determine whether a provider of services—a hospital, extended care facility, or home health agency—meets the conditions for participation in the program, and having determined that the provider meets the conditions, to certify the fact to the Secretary. State agencies would also determine whether independent laboratories meet the conditions which are required for coverage of laboratory services under part B. The Secretary would be required to use the services of State health departments or other appropriate State or local agencies in this way wherever the State agency is able and willing to perform this administrative function. In addition, the Secretary would be authorized to use such agencies for the following additional functions:

(*a*) Rendering consultative services to providers to assist them to establish and maintain necessary fiscal records and otherwise to meet the conditions for participation and to provide information necessary to derive operating costs so as to determine amounts to be paid for the providers' services;

(*b*) Rendering consultative services to providers and medical societies to assist in the establishment and testing of utilization review procedures.

To illustrate a consultative function a State agency could perform to assist providers to qualify, it could assist an extended care facility to establish a transfer agreement with a participating hospital.

The Secretary could select also either public or private organizations participating in administration of the programs to perform the consultative functions mentioned in (*a*) and (*b*), above. This would enable him to select the organization which he finds can most capably carry out these functions in the specific situation.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal hospital insurance trust fund would pay a fair share of the State agency's costs attributable to planning and coordination of the functions to be performed under the terms of the agreements, with those other activities for which the agency is responsible which relate to public and private programs for the provision of health services similar to those for which payment may be made under the proposed program.

(5) Role of public and private organizations

The committee's bill provides a considerable role for the participation of private organizations in the administration of both the hospital insurance plan the the supplementary plan.

Under the hospital insurance plan, groups of providers, or associations of providers on behalf of their members, could nominate a national, State, or other public or private agency or organization which they wished to have serve as a fiscal intermediary between themselves and the Federal Government. While it is expected that most providers would want to nominate a private organization, the bill would also permit nomination of a public agency (a State public health agency, for example) by providers which wished to have such an agency serve as fiscal intermediary.

A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.

The organization or agency serving as a fiscal intermediary under part A would, under agreement with the Secretary, determine the amount of payments due upon presentation of provider bills and make the payments. The Secretary would be permitted to enter into agreement with a nominated organization only if he finds that this would be consistent with effective and efficient administration and that the organization is able and willing to assist in the application of safeguards against unnecessary utilization of covered services, and only if the organization agrees to furnish him with such of the information it gathers in carrying out the agreement as he finds necessary. The agreement may include provision for the agency or organization to perform one or more of certain administrative duties other than the payment function. These would include providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions. The Government would provide advances of funds to the agencies or organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

The committee believes that medical benefits under the supplementary program in part B should be administered by the private sector. Private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians. Administration of other benefits under part B would be handled as is found most efficient and convenient to beneficiaries and persons providing health services.

The House-passed bill requires the Secretary, to the extent possible, to enter into contracts with carriers under which the carriers would perform specified administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations. These functions include: Determining the amount of payments due providers and other persons, and making the payments; auditing records of providers; determining whether providers meet the utilization review requirements under the program; assisting providers and other persons to develop procedures relating to utilization practices, and studying the effectiveness of such procedures; assisting in the application of safeguards against unnecessary utilization of covered services and in the establishment of review groups outside hospitals; serving as a channel of communication of information relating to the program's administration; and otherwise assisting in the administration of the supplementary plan.

Under the House bill, organizations nominated by providers of services (hospitals, extended care facilities, and home health agencies) could be used by the Secretary to reimburse these institutions and agencies on a reasonable cost basis for services covered under part A, and carriers would be used to make payments for services covered under part B, including payments to providers of services on a cost basis and for doctors bills on a reasonable charge basis. In addition, the House bill specifies that, except as otherwise provided, the Secretary may perform any of his functions directly or by contract.

The committee bill would permit a distribution of part B functions among carriers, organizations with which part A agreements are in effect, and contractors performing services in behalf of the Secretary in a way that is most efficient and convenient for hospitals and beneficiaries. These changes would eliminate the need for organizations selected to pay doctors' bills on a charge basis to acquire experience in paying hospitals on a cost basis. But as under House language, it would still be required that, to the extent possible, doctors would be paid through carriers. Under the committee changes, nominated organizations having experience with cost reimbursement could determine the amounts of payments and make such payments whether under part A or part B. In the absence of a suitable nominated organization, the Secretary could contract out all or part of this service or handle the function directly. Also, the committee bill would permit the Secretary to use carriers under part B to make payments only for services that are paid for on a charge basis unless the carrier is also an organization which is capable of handling payments for services on a cost basis.

The Secretary would be permitted to enter into contracts with carriers without regard to provisions of law relating to competitive bidding. However, he could enter into such a contract only if he found that the carrier would perform efficiently and effectively and if the carrier met such requirements as to financial responsibility, legal

authority, and such other matters as the Secretary found pertinent. It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable. The carrier would also have to maintain such records and furnish such information and reports as the Secretary finds necessary and, in addition, would have to establish procedures for fair review of beneficiary complaints regarding disallowed requests for payment and requests where the amount of payment is in controversy.

The contracts would be for a term of at least 1 year, and could be made automatically renewable. A contract would provide for payment of the carrier's cost of administration (including advances of funds for such purposes), as the Secretary determined to be necessary and proper for carrying out the functions covered by the contract. The Secretary could terminate a contract, after reasonable notice and opportunity for a hearing, if he found that the carrier had failed to substantially carry out the contract or was carrying it out in a manner inconsistent with the efficient administration of the supplementary medical insurance program.

The bill broadly defines a carrier with which the Secretary could contract as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. It is intended that a group of carriers will meet this definition and be eligible to enter into a contract with the Secretary. The definition would specifically include a health benefits plan duly sponsored or underwritten by an employee organization. With respect to hospitals, extended care facilities, and home health agencies, the definition also includes a public or private organization which is nominated by providers of services and which participates in administration of the hospital insurance plan. In addition, a State welfare agency which buys into the program for aged welfare recipients could act as the carrier for its recipients (if it met the other conditions of participation as a carrier).

In the performance of their contractual undertakings, the carriers and fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary.

(6) Appeals

The committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary medical insurance benefits and for hearings by

the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is $1,000 or more. (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program. It is intended that the remedies provided by these review procedures shall be exclusive.

4. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The hospital insurance system established by the committee-approved bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program would be newly established, with no past operating experience, but also because of the greater number of variable factors involved in a service benefit program than in a cash benefit one. However, the committee believes that the cost estimates are made under very conservative assumptions with respect to all foreseeable factors.

It is essential, in the view of the committee, that the developing operations of this new program should be carefully studied as they occur in the immediate future, so that the Congress and the executive branch can be kept as well informed as possible and as quickly as is feasible. Under these circumstances, the committee agrees with the suggestion which has been made that there should be a small continuing actuarial sample (of perhaps 0.1 percent of all eligible individuals), whose experience can be followed as promptly and as thoroughly as if the system related to only about 20,000 persons (under which circumstances, it would be possible to make many complete studies of the experience as rapidly as it develops, without the disadvantages from a time standpoint of handling the vast amount of data that arises for the millions of persons protected by the full program). In this connection, it will be essential for carriers involved in the processing and payment of claims to supply the necessary actuarial information promptly and in adequate fashion for the actuarial analyses to be made.

(*b*) *Financing policy*

(*1*) *Financing basis of committee-approved bill*

The contribution schedule contained in the committee-approved bill, as contrasted with that in the House-approved bill, for the hospital insurance program and the corresponding maximum earnings bases are as follows:

Calendar year	Earnings base		Employer-employee rate (percent)		Self-employed rate (percent)	
	Committee-approved bill	House-approved bill	Committee-approved bill	House-approved bill	Committee-approved bill	House-approved bill
1966	$6,600	$5,600	0.65	0.70	0.325	0.35
1967-70	6,600	5,600	1.00	1.00	.50	.50
1971-72	6,600	6,600	1.10	1.00	.55	.50
1973-75	6,600	6,600	1.20	1.10	.60	.55
1976-79	6,600	6,600	1.30	1.20	.65	.60
1980-86	6,600	6,600	1.50	1.40	.75	.70
1987 and after	6,600	6,600	1.70	1.60	.85	.80

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, the bill provides that income tax withholding statements (forms W–2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, until the railroad retirement system has at least as large a maximum earnings base as does the hospital insurance program, this program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions); thereafter, the Railroad Retirement Board would administer the hospital insurance program for railroad employees and annuitants, and the financial interchange provisions would be operative, just as they are for the cash benefits programs. *Fifth*, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

(2) Self-supporting nature of system

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, the committee has very carefully considered the cost aspects of the proposed hospital insurance system. In the same manner, the committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group that would be covered by this program would have their benefits, and the resulting administrative expenses, completely financed from general revenues, according to the provisions of the bill). Accordingly, the committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, as well as actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in a following section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program should desirably be made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future.

In starting a new program such as hospital insurance, it seems desirable to the committee that the program should be completely in actuarial balance. In order to accomplish this result, the committee has developed a contribution schedule that will meet this requirement, according to the underlying cost estimates.

(c) Hospitalization data and assumptions

(1) Past increases in hospital costs and in earnings

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1954 and up through 1963.

TABLE A.—*Comparison of annual increases in hospitalization costs and in earnings*

[In percent]

Calendar year	Increase over previous year	
	Average wages in covered employment	Average daily hospitalization costs
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average [1]	4.0	6.7

[1] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospitalization costs are based on a series of average daily costs (including not only room and board, but also other charges), prepared by the American Hospital Association.

The annual increases in earnings have fluctuated somewhat over the 10-year period, although there have not been very large deviations from the average annual rate of 4.0 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise have fluctuated from year to year around the average annual rate of 6.7 percent; the increases in the last 2 years were relatively low as compared with previous years.

Hospital costs then have been increasing at a faster rate than earnings. The differential between these two rates of increase has fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

The committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be. It would appear that, at the least, hospital costs would increase about 2 percent per year more than earnings for a few years and that, at the most, this differential rate would be 3 percent per year. It is recognized, of course, that these "minimum" and "maximum" assumptions result in a relatively wide spread in the cost estimates for hospital insurance proposals if the estimates are carried out for a number of years into the future.

(2) Assumptions underlying original cost estimates for the administration's bill, H.R. 3920 and S. 880, 88th Congress (the King-Anderson bill)

By way of background to the development of the cost estimates for the hospital insurance system that would be established by the committee-approved bill, there follows a discussion of cost estimates on the administration's proposals in the 88th Congress and in this Congress.

The actuarial cost estimates for H.R. 3920 and S. 880, 88th Congress, made at the time of its introduction in 1963 were presented in detail—as to assumptions, methodology, and results—in Actuarial Study No. 57 of the Social Security Administration.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being in the neighborhood of 3 percent per year—2.7 percent in the last 10 years.

A major consideration in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making and in presenting these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). The reason for this result is that, as indicated in Actuarial Study No. 57, the fundamental assumption was made that hospitalization costs would rise at the same rate over the long run as the total earnings level; however, contribution income would rise less rapidly than the total earn-

ings level unless the earnings base is kept up to date. Under these conditions, it is necessary that the base be kept up to date with the changes in the general level of earnings, since contributions depend on the covered earnings level, and this level is dampened if the earnings base is not raised as earnings go up. Accordingly, it was necessary in the actuarial cost estimates for hospitalization benefits in Actuarial Study No. 57 to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), the system will be kept up to date insofar as the earnings base and the deductibles are concerned.

The basic assumption underlying the actuarial cost estimates in Actuarial Study No. 57 was that the relationship between earnings and hospital costs would, on the average, be the same into the future as in the 1961 experience. Alternatively and equivalently, these assumptions meant that earnings and hospital costs will rise, on the average, at the same rate in the future and that the earnings base will be adjusted proportionately with changes in the earnings level.

(3) Alternative assumptions for hospitalization-benefits cost estimates

One alternative basis for the assumptions that have just been discussed would assume the continuation into the long-range future of recent trends in the relationship between hospitalization costs and the general wage level, while at the same time assuming that there would be no change in the maximum earnings base under the system.

In the recent past, the general earnings level has increased at a rate of about 4 percent a year, while hospital costs have risen about 7 percent a year, so that there is a differential of about 3 percent. Assuming the continuation of these trends into the *indefinite future* and assuming, at the same time, no change in the maximum earnings base would have the following effects:

(1) Eventually hospitalization costs would exceed 100 percent of the earnings of all workers in the country—let alone, of taxable earnings.

(2) Virtually everyone entitled to cash benefits under the system would have the maximum benefit prescribed under the law, since they would have their benefits figured on the maximum creditable earnings. The earnings of the lowest paid part-time workers would eventually rise to the present maximum earnings base.

(3) The cash benefits of the system would be only a very small proportion of a person's previous earnings.

(4) As a percentage of taxable payroll, the cost of the cash-benefits portion of the system would be considerably lower than it is presently estimated to be—to the extent of about 1¼ percent of taxable payroll.

Such an assumption was not used in the cost estimates because it is considered to be completely unrealistic—and could be considered an "impossible" one. It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually individuals—even currently employed workers, let alone older persons—could not afford to go to a hospital under such cost circumstances.

As a numerical example, consider a full-time male worker now earning the "typical" amount of $20 per day, or $5,200 per year. The

average daily cost for hospitalization (including not only room and board, but also other charges) for persons of all ages is about $40, currently, or twice the average daily wage. If wages increase 4 percent per year, and if hospital costs increase 7 percent per year—indefinitely into the future—then the following situation will occur:

Item	At present	In 20 years	In 50 years
Average daily wage	$20	$43.82	$142.13
Average daily hospitalization cost	$40	$154.79	$1,178.28
Ratio of hospital cost to average daily wage (percent)	200	353	829
Proportion of wage covered by $6,600 base (percent)	100	54	18

Consideration of the foregoing figures indicates that, whereas the cost of a hospital day now averages about 2 days' wages, then in 50 years if the assumed trends take place, the cost of a hospital day will be over 8 days' wages. Quite obviously, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a long period into the future.

(*4*) *Assumptions underlying original cost estimates for the administration's bill, H.R. 1 and S. 1, 89th Congress (the King-Anderson bill)*

The Advisory Council on Social Security Financing, which was appointed in 1963 and completed its work by the end of 1964, considered the subject of hospitalization benefits and made significant recommendations in this field that were quite similar to the corresponding provisions contained in the administration's bill, H.R. 1 and S. 1, 89th Congress, introduced in January 1965. Further details on the recommendations of the Advisory Council and on the cost assumptions that it suggested may be found in its report "The Status of the Social Security Program and Recommendations for Its Improvement" (app. V, 25th Annual Report of the Board of Trustees, H. Doc. No. 100, 89th Cong.).

The Advisory Council stressed that the assumptions used in estimating hospital insurance costs should be conservative (i.e., where judgment issues arise, they should be resolved in a direction that would yield a higher cost estimate). The assumptions suggested by the Advisory Council were that the estimated 1965 hospitalization costs should be assumed to increase in the future in relation to total earnings rates by a net differential of 2.7 percent per year for the first 5 years after 1965, with this differential then being assumed to decrease to zero over the next 5 years; thereafter, earnings are assumed to rise at an annual rate that is 0.5 percent greater than the increase in hospitalization costs.

The cost estimates made for H.R. 1 and S. 1 (as contained in Actuarial Study No. 59 of the Social Security Administration) were on the same basis as to hospitalization-cost assumptions as recommended by the Advisory Council. The long-range cost estimates were developed on the basis that the base figure for average daily hospitalization costs would be 1963 (since the cost estimates for both the cash benefits and the hospitalization benefits are founded on this basic assumption). This, in turn, meant that there was also the

coordinate assumption that the earnings base would, in the future, keep up to date with what $5,600 represented in 1963.

(5) Assumptions as to relative trends of hospitalization costs and earnings underlying cost estimate for committee-approved bill and for House-approved bill—H.R. 6675

As indicated previously, the committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. For the reasons brought out previously, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

Accordingly, for the purposes of the cost estimates in this report, the assumptions as to the relative trend of hospitalization costs as compared with the general earnings level have been modified somewhat as compared with the relatively conservative assumptions recommended by the Advisory Council. The same differential of hospital costs over earnings for the first 10 years is used, but thereafter the assumption is made that these two elements increase at the same rate (rather than having a negative one-half of 1 percent annual differential, as in the Advisory Council recommendations). In other words, the basis of the hospitalization cost trends used in the cost estimates of this report are on a more conservative basis than recommended by the Advisory Council and, in fact, are more conservative than those used by the insurance business for its estimates for proposals of this type. The assumptions as to the relative trends of hospitalization costs and wages as used here are the same as those used for the cost estimates for the House-approved bill.

(6) Assumptions as to hospital utilization rates underlying cost estimates for committee-approved bill and for House-approved bill—H.R. 6675

It should be pointed out that the hospital utilization assumptions for the cost estimates prepared by the Social Security Administration and also those in this report have always been founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for the various past proposals (H.R. 3920 and S. 880, 88th Congress; the Advisory Council plan; and H.R. 1 and S. 1, 89th Congress) were the same in all instances. In view of the fact that testimony of the insurance business and the Blue Cross stated their belief that higher utilization would develop (actually, by as much as 40 percent higher

in the early years of operation), higher utilization rates have been adopted than those used previously by the Social Security Administration. The increase in the early-year utilization rates is about 20 percent. Half of this can be attributed to changing the previous assumption of low-cost utilization rates in the early years to the assumption of the intermediate-cost rates then; the latter were previously used only after the program would be in operation for a few years and the beneficiaries would have better knowledge of the benefits available. The other half of the increase in the utilization rates can be said to represent a basic adjustment upward for all future years, which can be viewed as a safety factor.

In other words, the current estimates can be considered to be high-cost ones, as compared with the intermediate-cost ones formerly used by the Social Security Administration. Another factor that may be used to justify the higher utilization rates used in these cost estimates is the somewhat greater amount of hospitalization which might result from the availability of the physicians' services benefits for in-hospital cases made available under the supplementary medical insurance program contained in the committee-approved bill.

(7) Assumptions as to hospital per diem rates underlying cost estimates for House-approved bill and for committee-approved bill—H.R. 6675

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in Actuarial Study No. 59 of the Social Security Administration. These per diem costs were in close agreement with what the Blue Cross testimony indicated, although some 13 percent below the estimates of the insurance business. The reason for the latter differential is that the insurance business did not make as large an allowance for a lower average daily cost for persons aged 65 and over and for hospital expenses that are not related to inpatients.

(d) Results of cost estimates

(1) Summary of cost estimates for H.R. 1 and S. 1, 89th Congress, under various cost assumptions

Table B summarizes the cost estimates that would be made for H.R. 1 and S. 1, 89th Congress (the King-Anderson bill), under various cost assumptions that have been used in the past, and also under those that are being used for the committee-approved bill. This analysis is made, with a single plan as the base point, so as to show the effect of the various assumptions. The variations shown arise from changes in a number of the cost factors—the relative trend of hospitalization costs as compared with earnings; the period over which the cost estimates are made, and whether static or dynamic assumptions are involved; and the hospital utilization rates.

In all the previous cost estimates, it was assumed that the maximum taxable earnings base would be kept up to date, by periodic changes, with changes in the general earnings level, and also that the same would be true of any deductibles. In regard to the latter element, many of the proposals had provisions calling for increases in the deductible amounts as hospital costs increase in the future so that the condition was thus satisfied; this is the case in connection with the hospital and outpatient diagnostic deductibles and also the hospital and extended care facility coinsurance in the committee-approved bill.

With regard to the assumption that the earnings base would be kept up to date in the future, the committee believes that this is not a conservative assumption, since it seems to bind future Congresses into taking action in order to maintain the actuarial soundness of the hospital insurance system. It should be emphasized that the actuarial soundness of the cash benefits program under the old-age, survivors, and disability insurance system does not at all depend upon an assumption of the earnings base being adjusted upward when wages rise (but rather, on the contrary, the actuarial status of the system is improved under such circumstances. Accordingly, although the committee believes that, under the likely conditions of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the increase contained in the committee-approved bill (from the present $4,800 to $6,600), the conservative assumption should be made for the purposes of the actuarial cost estimates that no further increases will occur after 1966.

TABLE B.—*Summary of cost estimates for hospital insurance benefits of H.R. 1 and S. 1, 89th Congress, under various cost assumptions*

Assumptions as to earnings base	Assumptions as to relative trends of hospitalization costs and earnings	Estimated level-cost [1]
COST ESTIMATES PREPARED ON LONG-RANGE LEVEL-EARNINGS ASSUMPTIONS		
(1) Keeps up to date with what $5,600 was in 1963.	Over the long range, hospitalization costs and earnings increase at same rate from 1961 on.	0.67% (basis of Actuarial Study No. 57, 1963).
(2) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; in next 5 years, hospitalization costs, rise more rapidly than earnings—by a total differential of 10%; thereafter, hospitalization costs and earnings rise at same rate.	0.81% (basis of cost estimates developed for 1964 legislation).
(3) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then this differential is reduced to zero in next 5 years and after 1975 wages rise more rapidly than hospitalization costs by ½% per year.	0.84% (basis of cost estimates for Advisory Council and in Actuarial Study No. 59, 1965).
(4) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then this differential is reduced to zero in next 5 years; after 1975, hospitalization costs and wages increase at same rate.	0.87%.
(5) Keeps up to date with what $5,600 would be in 1966.	Same as in (4)	0.90%.
COST ESTIMATES PREPARED ON LONG-RANGE RISING-EARNINGS ASSUMPTIONS		
(6) Same as in (5)	Same as in (4)	0.96%.
(7) Remains at $5,600 through 1970; brought up to date by increase to $6,600 in 1971 and increased correspondingly every 5th year thereafter.	Same as in (4)	0.98%.
(8) Remains at $5,600 through 1970; increases to $6,600 in 1971 and then remains constant.	Same as in (4)	1.09%.[2]
(9) $6,600 in 1966 and then remains constant.	Same as in (4)	1.08%.[2]

[1] Except for items (1) and (2), which are on a perpetuity basis, the figures are for the level-cost over a 25-year period, expressed as a percentage of taxable payroll; includes margin so that trust fund balance at end of period equals the disbursements for that year.

[2] All the cost estimates for items (1) to (8) are based on the hospital utilization rates of Actuarial Study No. 59 of the Social Security Administration. The level cost for item (8) would be increased to 1.21% under the hospital utilization rates of the estimates of this report, while for item (9) the corresponding figure would be 1.20%.

(2) Level-costs of hospital and related benefits

As shown in footnote 2 of table B, the level cost of the hospital benefits that would be provided under H.R. 1 and S. 1, 89th Congress, is 1.20 percent of taxable payroll, under the assumptions that the earnings base would be the same as in the committee-approved bill and would not change after 1966, and that both hospitalization costs and general earnings will continue to rise during the entire 25-year period considered in the cost estimates. The corresponding level cost of the hospital and related benefits in the committee-approved bill is 1.31 percent of taxable payroll. The difference arises from several factors. A higher cost arises for the committee-approved bill because the self-employed contribute on a lower rate basis (i.e., at the employee rate instead of 1½ times the employee rate), because there are more insured persons (due to the transitional insured status provisions for certain persons aged 72 and over), and because of the inclusion of hospital benefits beyond 60 days (with coinsurance). On the other hand, there is a lower cost under the committee-approved bill because of the exclusion of prehospital home health services and because of the higher earnings base, but this only partially offsets the factors mentioned in the previous sentence.

The level-equivalent of the contribution schedule in the committee-approved bill (as described previously) is 1.32 percent of taxable payroll. Accordingly, these estimates indicate that the hospital insurance program is in actuarial balance under the assumptions made (and described previously).

The estimated level-cost of the hospital and related benefits of 1.31 percent consists predominantly of the cost of the hospital benefits. It does not seem feasible to attempt to subdivide the cost for the hospital benefits and the extended care facility benefits between these two categories. In the early years, virtually all of such costs will be for hospital benefits. Perhaps only about $25 to $50 million will be expended in 1967 for extended care facility benefits. In later years, it seems quite possible that greater use of posthospital extended care services will be made, thus tending to reduce the use of hospitals. From a cost standpoint, then, it seems desirable to consider hospital benefits and extended care facility benefits in combination, and it is estimated that the level-cost therefor is 1.26 percent of taxable payroll. The level cost of outpatient hospital diagnostic benefits is estimated at 0.01 percent of taxable payroll, with the cost in the first full year of operations being about $10 million. Finally, the estimated level-cost of the posthospital home health benefits is 0.04 percent of taxable payroll, a figure that allows for a considerable expansion of these services in the future (with the cost in the first full year of operations being estimated at less than $10 million.)

Table C indicates the changes in the actuarial balance of the hospital insurance program due to various changes made in the committee-approved bill, as compared with the House-approved bill.

TABLE C.—*Changes in actuarial balance of hospital insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, House-approved bill and committee-approved bill, based on 3.50 percent interest.*

[Percent]

Item	*Level-cost*
Actuarial balance under House-approved bill	0.00
Earnings base of $6,600 in all future years	+.01
Revised contribution schedule	+.09
Inclusion of services of medical specialists [1]	−.05
Increase in maximum home health services visits	−.01
Increase in maximum hospital benefit days	−.04
Inclusion of psychiatric hospitals	−.01
Transfer of outpatient diagnostic deductible to supplementary plan and introduction of 20 percent coinsurance	+.02
Actuarial balance under committee-approved bill	+.01

[1] Radiologists, anesthesiologists, pathologists, and physiatrists.

As indicated previously, one of the most important basic assumptions in the cost estimates presented here is that the earnings base is assumed to remain unchanged after it increases to $6,600 in 1966, even though for the period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in the committee-approved bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.1 percent would not be needed. Furthermore, under the foregoing conditions, if the hospital utilization experience followed the intermediate-cost assumptions made previously in Actuarial Study No. 59 of the Social Security Administration (increased by 10 percent for the estimates presented in this report), and if all other conditions (such as the relationship of hospitalization costs and general earnings) developed as they are set forth in the assumptions, then it is possible that the combined employer-employee contribution rate would not have to increase beyond 1 percent.

(3) Number of persons protected on July 1, 1966

It is estimated that on July 1, 1966, the total population of the United States (including American Samoa, Guam, Puerto Rico, and the Virgin Islands) who are aged 65 and over will be 19.10 million (after allowance for underenumeration in the census counts and in population projections based thereon).

The total number of such persons who are estimated to be eligible for the hospital and related benefits on the basis of insured status under the old-age, survivors, and disability insurance system and the railroad retirement system is 16.90 million, of whom 16.08 million are insured under old-age, survivors, and disability insurance only, 0.56 million are insured under railroad retirement only, and 0.26 million are insured under both systems. Of the remaining 2.20 million, about 1.95 million are estimated to be eligible for the hospital and related benefits under the transitional provision on eligibility of presently uninsured individuals, as contained in the committee-approved bill. The remaining 250,000 persons are not eligible for hospital and related benefits because they are active or retired employees who are eligible for more comprehensive benefits under the

Federal Employees Health Benefits Act of 1959 (200,000 persons), because they are alien residents who do not meet the residence and other requirements, or because they are subversives.

The cost for the 1.95 million persons who would be blanketed in for the hospital and related benefits is met from the general fund of the Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis or in the following discussions of the progress of the hospital insurance trust fund. A later portion of this section, however, discusses these costs for the blanketed-in group.

(4) Future operations of hospital insurance trust fund

Table D shows the estimated operation of the hospital insurance trust fund under the committee-approved bill. According to this estimate, the balance in the trust fund would grow steadily in the future, increasing from about $450 million at the end of 1966 to $1.9 billion 5 years later. Over the long range, the trust fund would build up steadily, reaching $10.1 billion in 1990 (representing the outgo for 1.0 years at the level of that time). The balance in the trust fund at the end of each calendar year in the early years of operation would be somewhat larger than shown in table D if the appropriations from the general fund of the Treasury are made at the beginning of each fiscal year (as a provision added by the committee-approved bill would permit). If this is done at the beginning of fiscal year 1967 (on July 1, 1966), the balance in the trust fund at the end of calendar year 1966 will be about $150 million higher.

Table D is based on the assumption that the hospital and related benefits for railroad workers and annuitants will be administered through the hospital insurance trust fund. However, if the maximum earnings base under the Railroad Retirement Tax Act is increased to at least that under the hospital insurance system, thereafter the Railroad Retirement Board will administer these benefits and will receive the contributions (at the same rate) from railroad workers. At the same time, the financial interchange provisions which are applicable under present law to the cash benefits would be operative for the hospital and related benefits (the detailed operation and the function of the financial interchange provision are explained in par. (c)(6) of the section dealing with the actuarial cost estimates for the old-age, survivors, and disability insurance system). As a result, there would be no net financial effect on the hospital insurance program whether or not such transfer of administration occurs.

TABLE D.—*Estimated progress of hospital insurance trust fund*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	$1,548	$1,055	[1] $55	$15	$453
1967	2,766	2,358	71	15	805
1968	3,025	2,574	77	29	1,208
1969	3,120	2,807	84	41	1,478
1970	3,225	3,060	92	48	1,599
1971	3,609	3,293	99	53	1,869
1972	3,776	3,535	106	60	2,064
1973	4,251	3,788	114	68	2,481
1974	4,474	4,053	122	80	2,860
1975	4,655	4,330	130	88	3,143
1980	6,569	5,680	170	153	5,479
1985	7,540	7,341	220	252	8,188
1990	9,595	9,414	282	310	10,098

[1] Including administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons who would be covered for the benefits of this program, the cost for whom is borne out of the general funds of the Treasury, are not shown in the above figures. The figures in this table are based on the assumption that railroad workers will be covered directly by this program. (See table E for data on the basis that the Railroad Retirement Board will administer their benefits.)

Under the circumstances of such a transfer, both the contributions and the benefit payments made directly through the hospital insurance trust fund would be lower than shown in table D. The extent of the decrease in benefit payments and the size of the financial interchange payments will depend on the extent to which persons eligible under both the railroad system and the hospital insurance system choose to receive their payments through the former. The financial results are shown in table E under the extreme assumption that all dual eligibles elect to receive benefits through the railroad system.

Not included in the figures in table E are any excesses of contributions collected by the railroad retirement system over the amount to be credited, through the financial interchange, to the hospital insurance trust fund; such excesses would result if the railroad retirement earnings base is higher than that under hospital insurance. Conversely, the contributions collected by the railroad retirement system could be slightly lower than the amount to be credited to the hospital insurance trust fund if the two earnings bases are the same, since the railroad retirement base is on a monthly basis, rather than an annual one (for example, an individual earning $500 per month for 6 months of a year and $600 per month for the other 6 months would have all his wages covered under a $6,600 annual base, but not under a $550 monthly base). There could also be a difference if subsequently the railroad retirement base were not increased as rapidly as any increases that might occur in the hospital insurance base. In any event, the hospital insurance trust fund receives the same amount, and the railroad retirement account has either an excess or a deficit in this respect.

Also not included in table E are the benefit costs of certain services furnished in Canada that are available only to railroad eligibles. These have an estimated cost initially of about $200,000 per year, financed entirely by the railroad retirement system, and are not involved in the financial interchange transactions.

TABLE E.—*Estimated financial results if railroad workers and annuitants receive hospital and related benefits through railroad retirement account*

[In millions]

Calendar year	Contributions [1]	Benefit payments and administrative expenses [1 2]	Financial interchange payment [2 3]
1966	$29	$39	$10
1967	48	84	36
1968	50	90	40
1969	50	94	44
1970	50	99	49
1971	54	103	49
1972	55	106	51
1973	59	109	50
1974	60	113	53
1975	60	115	55
1980	74	116	42
1985	75	116	41
1990	85	114	29

[1] Amounts involved in the financial interchange transactions.
[2] Based on the assumption that all dual eligibles elect to receive benefits from the railroad retirement system.
[3] Payments from the hospital insurance trust fund to the railroad retirement account (shown on an accrual basis).

(e) Cost estimate for hospital benefits for noninsured persons paid from general funds

The committee-approved bill would provide hospital and related benefits not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also for most persons aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. Such benefit protection would be provided to any person aged 65 and over on July 1, 1966, who is not eligible as an old-age, survivors, and disability insurance or railroad retirement beneficiary and who (*a*) is not an employee of the Federal Government or a retired Federal employee enrolled for health benefits under the Federal Employees Health Benefits Act of 1959, or the wife or widow of such an individual; (*b*) is not a member of a subversive organization and has not been convicted of subversive activities; and (*c*) is a citizen or is an alien lawfully admitted for permanent residence who has had at least 10 years of continuous residence.

Persons meeting such conditions who attain age 65 before 1968 also would qualify for the hospital benefits, while those attaining age 65 after 1967 must have some old-age, survivors, and disability insurance or railroad retirement coverage to qualify; namely, three quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., six quarters of coverage for attainment of age 65 in 1968, nine quarters for 1969, etc.). This transitional provision "washes out" for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully insured status requirement for monthly benefits for such categories is then no greater than the special insured status requirement.

The benefits for the "noninsured" group would be paid from the health insurance trust fund, but with reimbursement therefor from

the general fund of the Treasury on a current basis, or even in advance for the fiscal year, at the beginning thereof or at later dates.

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

Calendar year:	*Cost to General Treasury*
1966 (last 6 months)	$145
1967	285
1968	280
1969	270
1970	265

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

5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY MEDICAL INSURANCE SYSTEM

(*a*) *Summary of actuarial cost estimates*

The supplementary medical insurance system that would be established by the committee-approved bill has an estimated cost for benefit payments incurred and for administrative expenses that would adequately be met during the first 2 years of operation (1967–68) by the individual premium rates prescribed plus the equal matching contributions from the general fund of the Treasury. Both contributions and benefit payments would begin in January 1967. In subsequent years, the committee-approved bill provides for appropriate adjustment of the premium rates so as to assure that the program will be adequately financed, along with the establishment of sufficient contingency reserves. Although provision is made for an advance appropriation from general revenues to provide a contingency reserve during the period January 1967 through December 1968, it is believed that this will not actually have to be drawn upon, but nonetheless it serves as a desirable safeguard to the financing basis of the program.

Just as in the case of the hospital insurance system, it is essential that the operating experience of a vast new program such as this should be subject to prompt, thorough actuarial review and study. Accordingly, the committee approves of the suggestion that has been made for a small random sample of the eligibles to be maintained on a current basis, so as to permit intensive study by the actuary without the delay that would be inherent in attempting to obtain operating experience data for the entire group of persons covered under the system.

(*b*) *Financing policy*

(*1*) *Self-supporting nature of system.*

The committee has recommended the establishment of a supplementary medical insurance program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over in the United States (excluding only those aliens who have not been lawfully admitted for permanent residence or who have not had 10 continuous years of residence). This program is intended to be

completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury. Initially (for the period January 1967 through December 1968), the premium rate is established at $3 per month, so that the total income of the system per participant per month will be $6. Persons who do not elect to come into the system at as early a time as possible will generally have to pay a higher premium rate than $3. Under the committee-approved bill, the monthly premium rate can be adjusted for future years after 1968, so as to reflect the expected experience, including an allowance for a margin for contingencies. All financial operations for this program would be handled through a separate fund, the supplementary medical insurance trust fund.

The committee-approved bill also provides for establishment of an advance appropriation from the general funds of the Treasury that will serve as an initial contingency reserve in an amount equal to $18 (or 6 months' per capita contributions from the general funds of the Treasury) times the number of individuals who are estimated to be eligible for participation in January 1967 (an estimated 19.15 million persons). This amount, which is approximately $345 million, would be appropriated, but it would not actually be transferred to the supplementary medical insurance trust fund unless, and until, some of it would be needed. This contingency amount would be available only during the first 2 years of operations (January 1967 to December 1968), and any amounts actually transferred to the trust fund would be subject to repayment to the general funds of the Treasury (without interest).

(2) Actuarial soundness of system

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary medical insurance program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary medical insurance system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary medical insurance program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

(c) Results of cost estimates

(1) Cost assumptions

Only a relatively small amount of data is available in regard to the physicians' services and other medical services that would be covered by the supplementary medical insurance system. The cost estimates used in determining the premium rate to be charged to individuals, along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the

Connecticut 65 program, and various information obtained by the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The cost estimates have been made on a conservative basis—as seems essential in a newly established program of this type for persons aged 65 and over, most of whom have not previously had such insurance. It is believed that the $6 total per capita income of the system (from the premiums of the individuals and the matching Government contributions) will be fully adequate to meet the costs of administration and the benefit payments incurred, as well as to build up a relatively small contingency reserve. It is believed that there will be no need to draw upon the advance appropriation that is provided from general revenues.

Two cost estimates have been presented in regard to the possible per capita cost. Under the low-cost estimate, the benefits and administrative expenses will, on an accrual basis, represent about 70 percent of the contribution income, whereas under the high-cost estimate, the corresponding ratio will be almost 95 percent.

In an individual voluntary-election program such as this, it is impossible to predict accurately in advance what proportion of those eligible to participate in the program will actually do so. Accordingly, the cost estimates have been presented on two bases—an assumed 80-percent participation and an assumed 95-percent participation. Both of these estimates assume that virtually all State public assistance agencies will "buy in" for their old-age assistance recipients.

The same per capita cost has been used for the two participation assumptions. It could be argued that with less than complete coverage, such as the 80-percent assumption, there would be antiselection against the program and that thus a higher per capita cost should be used. Although there may be some validity to this argument, there is the point on the other side of the question that those who do not participate will consist, to a considerable extent, of uninformed persons with low incomes who will not see the need or have the foresight to participate. The per capita cost for this category will not be significantly lower than the average. Furthermore, the experience under group health insurance indicates that 75-percent participation is adequate protection against antiselection.

It is recognized that there could be a very considerable element of antiselection in an individual voluntary program, such as this, if the insured person were required to pay the full cost. However, since, under the supplementary medical insurance program, half of the premium is paid from general revenues, the amount paid by the individual is low enough to be very attractive to even the lowest cost groups.

If participation should fall to a very low level, the per capita cost would rise substantially due to antiselection. In this event, however, the initial contingency fund would be a correspondingly larger proportion of the income received.

(2) Short-range operations of supplementary medical insurance trust fund

Table F presents estimates of the operation of the supplementary medical insurance trust fund for the first 2 years of operation, 1967–68. As indicated previously, four sets of estimates are given, under different assumptions as to low- and high-cost estimates and as to low and high

participation. A significant balance in the trust fund develops in 1967, because of the lag involved in making benefit payments, since there are the factors of administrative processing and of the deductible that must be met first before any benefits are payable. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of January 1967, and the matching Government contributions will go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of $455 to $540 million at the end of 1967, and between $695 and $825 million at the end of 1968. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1967 will be between $315 and $385 million, and will be about $50 million higher at the end of 1968.

TABLE F.—*Estimated progress of supplementary medical insurance trust fund*

[In millions]

Calendar year	Contributions		Benefit payments	Administrative expenses [1]	Interest on fund	Balance in fund at end of year
	Participants	Government				
	Low-cost estimate, 80-percent participation					
1967	$555	$555	$590	$75	$10	$455
1968	565	565	830	80	20	695
	Low-cost estimate, 95-percent participation					
1967	$660	$660	$700	$90	$10	$540
1968	670	670	985	95	25	825
	High-cost estimate, 80-percent participation					
1967	$555	$555	$705	$95	$5	$315
1968	565	565	1,000	100	15	360
	High-cost estimate, 95-percent participation					
1967	$600	$600	$835	$110	$10	$385
1968	670	670	1,190	115	15	435

[1] Administrative expenses shown include both those for the full year 1967 and such expenses as incurred in 1965 and 1966.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during 1967–68 (to be used only if needed and to be repayable).

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

(*a*) *Background*

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security

Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and over 246,000 aged were aided in March 1965. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs."

Under the House bill, after an interim period ending June 30, 1967, all States would have to adopt the new program or lose Federal matching as to vendor medical payments since the current provisions of law would expire at that time. Under the committee bill the States will have the option of participating under the new program or continuing to operate under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program). Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(*b*) *State plan requirements*

(*1*) *Standard provisions*

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

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.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, the committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that, effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, the committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

The committee's bill would add a requirement that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. This amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new title XIX, requiring States to have an authority or authorities responsible for establishing and maintaining standards for private or public institutions in which recipients may receive care or services.

The committee also added an amendment to require that, after June 30, 1967, private and public medical institutions must meet standards (which may be in addition to the standards prescribed by the State) relating to protection against fire and other hazards to the health and safety of individuals, which are established by the Secretary of Health, Education, and Welfare. The committee assumes that the standards prescribed by many States at the present time will meet or exceed those prescribed by the Secretary.

The House bill provided that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or

that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State supervised, the same State agency shall supervise the administration of title XIX.

The committee believes that the States should be given the opportunity to select the agency they wish to administer the program. A number of witnesses appearing before the committee have expressed the belief that the State health agency should be given the primary responsibility under this program. The committee bill leaves this decision wholly to the States with the sole requirement that the determination of eligibility for medical assistance be made by the State or local agency administering State plans approved under title I or XVI. The committee agrees with the statement in the House report that the welfare agencies have "long experience and skill in determination of eligibility."

The committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the new program, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individuals. This would include the eligibility determining function. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of the committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. The committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

The committee hopes that there will be continuing evaluation of all State plan requirements in relation to the basic objectives of the legislation.

(c) Eligibility for medical assistance

Under the committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. It is only if this group is provided for that States may include medical assistance to the less needy.

Under the committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various categories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

The committee has amended the House bill, however, so that this provision as to comparability does not apply in the case of services in institutions for tuberculosis or mental diseases. Federal financial participation is authorized only with respect to recipients aged 65 and over in mental and tuberculosis institutions so it would not be appropriate to include them within the scope of this provision.

(d) Determination of need for medical assistance

The committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that

which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exeeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, the committee bill requires that the State's standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus,

before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

This determination must be made by the agency administering the old-age assistance or combined adult program; i.e., the welfare agency.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similar charge, or of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect to require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. The committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles or cost sharing shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, the committee's bill provides that the States make provisions, for individuals 65 years or older who are included in the new plan, of the cost of any deductible or cost sharing imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the

State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibit adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under the committee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) *Scope and definition of medical services*

"Medical assistance" is defined under the bill to mean payment of all or part of the cost of care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406 (b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

The House bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.
Outpatient hospital services.
Other laboratory and X-ray services.
Skilled nursing home services.
Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

These minimum items of service are to become effective July 1, 1967, for States having plans in effect; until then a State plan must include—as now provided in titles I and XVI—some institutional, and some noninstitutional services.

The committee believed that some dental services should be required as to individuals under the age of 21. The committee plan limits the required "skilled nursing home services" to individuals 21 or older

and excludes from the definition of the required "in-patient hospital services and" skilled nursing home services those services which are in an institution for tuberculosis and mental diseases. This latter amendment would help make it clear that it is optional rather than mandatory for a State to include services for the aged in tuberculosis or mental institutions.

Other items of medical service which the States may, if they wish, include in their plans are:

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.

Home health services.

Clinic service.

Skill nursing home services (for persons under 21).

Private duty nursing service.

Dental service (for persons 21 or over).

In-patient hospital and skilled nursing home services for persons 65 or over in an institution for tuberculosis or mental diseases.

Physical therapy and related services.

Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.

Other diagnostic, screening, preventive, and rehabilitative services.

Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of in-patient hospital services for the number of days of care provided under the plan.

Among the items of medical services which the States may include is 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. Under this provision, a State may, it it wishes, include medical and remedial services provided by chiropractors, optometrists, and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan, the committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometrist to provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age

with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the House bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. The committee has amended the House bill so that the special provisions will only apply as to medical assistance to aged persons in mental institutions. These provisions are identical with those included in title II, part 3, of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude 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. Thus, States will include within the scope of their plan all children under the age of 21—whether or not they are attending school or taking a program of vocational training—who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV.

The Secretary would be prohibited from approving any plan which imposed a residence or citizenship requirement that goes beyond those now in title I and title XVI as they relate to the medical assistance for the aged program. In addition, the Secretary is directed not to approve any State plan for medical assistance if he finds that the approval and operation of the plan will result in a reduction in the level of aid or assistance provided for eligible individuals under title I, IV, X, XIV, or XVI. An exception is provided allowing States to reduce such aid to the extent that assistance now provided under titles I, IV, IX, XIV, and XVI is to be provided under title XIX. The reason the committee recommends the inclusion of this provision is to make certain that States do not divert funds from the provision of basic maintenance to the provision of medical care. If the Secretary should find that his approval of a title XIX plan would result in a reduction of aid or assistance for persons receiving basic maintenance under the public assistance titles of the Social Security Act (except as specified above) he may not approve such a plan under title XIX. The committee recognizes the need and urgency for States to maintain, if not improve, the level of basic maintenance provided for needy people

under the public assistance programs. The provision is intended to prevent any unwarranted diversion of funds from basic maintenance to medical care.

(g) *Financing of medical assistance*

The committee bill provides for payments under title XIX, beginning with the quarter commencing January 1, 1966. States with approved plans would receive an amount equal to the Federal medical assistance percentage of the total amount expended during a quarter as medical assistance under the State plan. This percentage is described below. The amount expended as medical assistance for purposes of Federal matching include expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under one of the Federal-State public assistance programs. This may include payment of premiums for those individuals covered under agreements between the State and the Secretary, and also for other money payment recipients who are eligible under part B of title XVIII. In addition, expenditures for other insurance premiums for medical or any other type of remedial care or the cost thereof are matchable as medical assistance. (The definitions of assistance in the public assistance titles of the Social Security Act would also be amended to include similar provisions.)

In addition, the States are to receive 75 percent of so much of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan as are attributable to the compensation of skilled professional medical personnel and staff directly supporting such personnel of the State agency or the local agency administering the plan in the political subdivision. This provision was included in order to provide adequate Federal financial support for the staffing of the State and local public welfare departments by such skilled professional medical personnel and staff directly supporting such personnel as may be necessary. Such staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job as well as the clerical staff, directly associated with the professional staff, and the necessary travel and other closely related expenditures. The committee has amended the House bill to also authorize Federal participation in the cost of training skilled professional medical personnel and staff directly supporting such personnel.

It is very likely that some people in need of medical assistance will need related social services in order to receive the full benefits of the program. Under the 1962 public welfare amendments, States may receive 75 percent Federal sharing in the cost of services provided to persons receiving aid under titles I, IV, X, XIV, and XVI to former recipients of assistance under these titles and persons likely to become recipients of aid under these titles. Thus adequate provisions are already available to help the States finance the provision of social services to those receiving medical assistance or the cost of training staff to provide such services and no such provision is included in the new title.

In addition, the States are to receive one-half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal marching. States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above the national average shall receive correspondingly lower percentages but not less than 50 percent. The medical assistance percentages for Puerto Rico, the Virgin Islands, and Guam shall be 55 percent. The method of determining the Federal medical assistance percentage and the frequency of its determination and promulgation are (after the initial promulgation for the period January 1, 1966, to June 30, 1967) already specified in the law.

There is a special provision for adjustment of the Federal medical assistance percentage for any State which might not otherwise receive full advantage from the title XIX formula. It is provided that during the period from January 1, 1966, through June 30, 1969, the Federal medical assistance percentage under title XIX for any State shall not be less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. The computation is made by determining the amount of Federal payments made to each State for fiscal year 1965 under all of the public assistance titles, which would not have been payable except for the making of vendor medical payments. This amount of Federal payments is compared with the total amount of vendor medical expenditures under the public assistance plans (whether below or above the matching ceilings under the Federal statutory formulas) to give the Federal share of medical expenditures by the State during fiscal year 1965. The raising of the Federal medical assistance percentage to 105 percent of the Federal share of medical expenditures for 1965 will obviate certain inequities in the various formulas and will enable a few States which might not otherwise do so to receive some additional Federal funds as an incentive for an improved program.

Provisions relating to the availability of Federal sharing in the cost of medical assistance for persons 65 years of age or older who are patients in mental hospitals specify that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that the additional funds being received are being used to extend and improve the mental health program of the States. Comparable provisions appear in title II, part 3, of the bill, and are explained more fully in that part of this report relating to title II.

The provisions of title IV, section 405 of the bill, described elsewhere in this report are designed to assure that the additional Federal funds which are to accrue to the States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.

The bill sets forth provisions comparable to those which are in other of the public assistance titles of the Social Security Act describing the procedure by which the State submits its estimates of the funds it will need and receives payments under its approved plan, and the procedures to be followed in the event it should become necessary to question the continued receipt of Federal funds under the new title.

There is also a new provision limiting payments made under the new title to States making a satisfactory showing of efforts toward broadening the scope of care and services made available under the plan. This showing must be such that the Secretary is reasonably convinced the program of medical assistance will have such liberalized eligibility requirements and comprehensive care and services, including needed social services to achieve independence or self-care that by July 1, 1975, assistance and services needed will be available to substantially all individuals who meet the State's eligibility standards with respect to income and resources. This provision was included in order to encourage the continued development in the States of a broadened and more liberalized medical assistance program so that all persons who meet the State's test of need, whose own resources, and the resources available to them under other programs for medical care, including those established for Federal matching under this bill, are insufficient, will receive the medical care which they need by 1975.

(*h*) *Miscellaneous provisions*

Title XIX would under the provisions of the committee bill become effective January 1, 1966. No payments may be made to a State under title I, IV, X, XIV, or XVI with respect to aid or assistance in the form of medical or other types of remedial care for any period for which such State receives payment under title XIX. When a title XIX plan has gone into effect pursuant to the bill, all vendor medical payments made on or after the effective date (and administrative costs on or after the effective date, which are related to vendor medical payments) will be accounted for under title XIX, and not under the other titles.

The bill also makes technical and conforming amendments.

(*i*) *Cost of medical assistance*

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed $100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX [1]

[In thousands of dollars]

State	Increase available under title XIX [1]	State	Increase available under title XIX [1]
Total	$238,005	Missouri	$350
		Montana	27
Alabama	1,045	Nebraska	1,511
Alaska	5	Nevada	263
Arizona	19	New Hampshire	1,931
Arkansas	3,905	New Jersey	5,559
California	20,411	New Mexico	1,634
Colorado	2,689	New York	46,580
Connecticut	3,922	North Carolina	2,890
Delaware	8	North Dakota	3,809
District of Columbia	344	Ohio	2,871
Florida	684	Oklahoma	14,752
Georgia	363	Oregon	1,291
Hawaii	898	Pennsylvania	3,098
Idaho	477	Rhode Island	2,437
Illinois	18,395	South Carolina	2,133
Indiana	2,136	South Dakota	148
Iowa	5,315	Tennessee	324
Kansas	5,808	Texas	1,237
Kentucky	262	Utah	3,028
Louisiana	3,950	Vermont	330
Maine	781	Virginia	159
Maryland	141	Washington	2,290
Massachusetts	16,614	West Virginia	2,260
Michigan	3,715	Wisconsin	17,031
Minnesota	27,578	Wyoming	280
Mississippi	317		

[1] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

B. Child Health and Welfare Amendments

1. SUMMARY OF COMMITTEE ACTION

The committee believes that the proposals embodied in part 1, title II of its bill will help to improve the health care of many low-income preschool and school age children and youth.

The committee's bill would make changes in the three areas noted below.

(1) The House bill increases the amounts authorized for maternal and child health services and crippled children's services under title V of the Social Security Act in order to assist the States to move toward the goal of extending such services with a view to making them reasonably available to children in all parts of the State by July 1, 1975. The committee bill makes a similar increase as to the child welfare program.

(2) The bill authorizes grants for the training of personnel to serve crippled children, particularly mentally retarded children and children with multiple handicaps, and;

(3) The House bill authorizes a new 5-year program of special project grants to provide comprehensive health care and services for children of school age and for preschool children. The committee bill increases these authorizations in the last 3 years so as to provide funds for project grants for emotionally disturbed children.

(*a*) *Maternal and child health services*

The amount of Federal funds going into maternal and child health services in the fiscal year 1964 was approximately $28 million. State and local funds were more than three times as much, about $92 million.

The committee believes that increases in the child population and the cost of medical care, wide variations among the States in maternal and infant mortality, and the uneven distribution of basic health services indicate the need for additional Federal support in order to help States make their maternal and child health services available to children in all parts of the State by July 1, 1975.

The committee bill, like the House bill, would increase existing ceilings on authorizations for appropriations for maternal and child health services to $45 million (now $40 million) for the fiscal year ending June 30, 1966; to $50 million (now $40 million) for the fiscal year ending June 30, 1967; to $55 million (now $45 million) for the fiscal years ending June 30, 1968 and 1969; and to $60 million (now $50 million) for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

(*b*) *Crippled children's services*

About $29 million of Federal funds was expended for services for crippled children in fiscal year 1964. Expenditures from State and local funds were more than twice as much—nearly $60 million.

Differences in rate of service among States is considerable, however, the highest being 165 per 10,000, the lowest 15. This unevenness is indicative of the need for considerable growth of these programs in many States. Many crippled children or children with potentially crippling conditions do not receive needed care because their conditions may not be included in the State's program. For example, a number of States do not include children with epilepsy; others do not include children with strabismus, neglect of which often results in loss of vision in the affected eye; some States do not include children with hearing impairments. The increased funds will also help States to extend their programs and further broaden their definitions of "crippling." A major reason for these deficiencies in State programs is inadequate funds.

The committee bill, like the House bill, would increase existing ceilings on authorizations for appropriations for crippled children's services to $45 million (now $40 million) for the fiscal year ending June 30, 1966; to $50 million (now $40 million) for the fiscal year ending June 30, 1967; to $55 million (now $45 million) for the fiscal years ending June 30, 1968 and 1969; and to $60 million (now $50 million) for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Such increases would assist the States to move toward the goal of extending crippled children's services with a view to making such services available to children in all parts of the State by July 1, 1975.

(*c*) *Child welfare services*

The fact that substantial State and local effort is now being made in the financing of child welfare services is indicated by figures showing that, in 1964, State and local funds constituted 91 percent of the $313 million expended for this program.

The committee added an amendment to bring the authorizations for funds for child welfare services in line with the revised authorizations for maternal and child health services and crippled children's services contained in the House-passed bill. Under this amendment the authorization for services would be $45 million (now $40 million) for the year ending June 30, 1966; $50 million (now $45 million) for the fiscal year ending June 30, 1967; $55 million (now $45 million) for the fiscal year ending June 30, 1968; $55 million (now $50 million) for the fiscal year ending 1969; $60 million (now $50 million) in the fiscal year ending June 30, 1970 and thereafter.

The additional authorizations, although relatively small, will, it is hoped, help States to provide more effective social services for children in such areas as neglect, and abuse, adoption, foster care, homemaker service, day care services, and services to mentally retarded children and their parents.

The committee also added an amendment which would remove the earmarking of funds for day care services, incorporated into the Public Welfare Amendments of 1962, because experience has shown that earmarking is no longer necessary in order to stimulate the initiation and expansion of day care services in the States. Day care services have thus now been recognized as an integral part of child welfare services and it is hoped that the development of day care services will be stimulated by the increase in authorizations.

(d) Training of professional personnel for the care of crippled children

The committee's bill would authorize a program of grants to institutions of higher learning for training (and related costs) of professional personnel such as physicians, psychologists, nurses, dentists, and social workers for work with crippled children and particularly mentally retarded children and those with multiple handicaps. Authorizations would be $5 million for the fiscal year ending June 30, 1967, $10 million for the fiscal year ending June 30, 1968, and $17.5 million for each fiscal year thereafter.

Of the 4.1 million children born each year about 3 percent—at birth or later—will be classified as mentally retarded. The 27,000 children in 1963 who were served by the 92 clinics in the country supported with maternal and child health and crippled children's funds represent only a small fraction of the children who need this kind of help.

The growth of programs for children with various handicapping conditions including those who are mentally retarded and the construction of new university centers for clinical services and training are increasing the demands for adequate trained professional personnel.

The training of health personnel authorized is not intended to, and in your committee's judgment will not, in any way duplicate other programs of training (such as those for teachers) of personnel to work with the mentally retarded.

(e) Payment for inpatient hospital services

The bill also provides for payment of the reasonable cost of inpatient hospital services provided under the State plans for maternal and child health services and crippled children's services. Reasonable costs are to be determined in accordance with standards approved by the Secretary.

(f) Special project grants for low-income school and preschool children

(i) Comprehensive health care services

The House bill would authorize a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare for children in low-income families.

The health needs of preschool children and children of school age, particularly children from low-income families, are not being fully met. The increase in the child population is resulting in great crowding of clinics available to low-income families and inadequate preventive health services and medical care for their children.

The committee is convinced that effective health supervision for children during the years before entering school would help considerably to get them ready for school and reduce the extent of the need for school health services for children in the first year of school. Such care should also be extended through adolescence.

There is evidence that many communities are finding that they do not have adequate resources to which children can be referred for diagnosis and treatment when they are found to be in need of treatment through school health programs and their resources for the examination, diagnosis, and treatment of preschool children to help them prepare to enter school are also too few and too crowded.

The committee's proposal will make possible programs organized to make maximum use of available community medical services and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals.

To be eligible for a grant a project must provide for—

(1) coordination with and utilization of other State and local health, welfare, and education programs for such children;

(2) payment of reasonable cost of inpatient hospital services;

(3) treatment, correction of defects, or aftercare to be available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and

(4) inclusion of such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, medical or dental, as required by the Secretary.

A full report with evaluation and recommendations is to be submitted to the President for transmission to the Congress before July 1, 1969.

The grants would be available to the State health agency or with its consent to the health agency of any political subdivision of the State, to the State agency administering or supervising the crippled children's program, to schools of medicine (with appropriate participation by schools of dentistry) and to teaching hospitals affiliated with schools of medicine.

The grants would pay not to exceed 75 percent of the cost of projects. The committee recognizes, however, that non-Federal funds may have to be derived from a variety of sources, particularly at the beginning of the program. These might include existing funds and activities of the grantee agency; funds, equipment, time of personnel, or space

made available by other agencies; or similar items or gifts from other sources.

The committee is aware that other committees of the Congress have before them legislative proposals dealing with school and preschool children. The committee is unaware of any duplication of the services provided in the special project health grants for school and preschool children incorporated in the proposed new section 532 of title V of the Social Security Act and no duplication is intended. Furthermore, the Appropriations Committee will have an opportunity to look at these programs at the same time and evaluate their interrelationships.

Authorizations for appropriations would be—

$15 million for the fiscal year ending June 30, 1966;
$35 million for the fiscal year ending June 30, 1967;
$40 million for the fiscal year ending June 30, 1968; and
$45 million for the fiscal year ending June 30, 1969, and
$50 million for the fiscal year ending June 30, 1970.

(*ii*) *Emotionally disturbed children*

The committee added an amendment which would (1) authorize Federal grants for projects providing for identification, care, and treatment of children who are or are in danger of becoming emotionally disturbed; (2) increase the authorization for project grants for school age and preschool children by $5 million each for fiscal years ending June 30, 1968, June 30, 1969, and June 30, 1970; and (3) authorize $500,000 a year for fiscal years 1966 and 1967 for project grants for research and studies or resources, methods, and practices for the diagnosis and treatment of mental illness in children.

The committee is concerned with the present lack of facilities and treatment for emotionally disturbed children and believes that better early detection, treatment, and followup of such conditions can avoid many serious problems in adulthood. It was impressed with that section of the report of the Warren Commission which stated that, at 13, Lee Harvey Oswald was found by a child guidance clinic to be of more than average intelligence but with a serious and deep-seated emotional problem and it was recommended that both he and his mother receive treatment. But, reads the Warren Commission report—

> when one of the city's clinics did find room to handle him, for some reason the record does not show, advantage was never taken of the chance afforded to Oswald.

Experts estimate that there are about 500,000 children in the Nation suffering from evident or borderline psychosis. Not all of these children can be labeled potential Lee Oswalds, but thousands of them harbor potential for harm to themselves and to society. Of these 500,000 children only 10,000—or 2 percent—are known to be under some sort of treatment.

The committee amendment would be a modest start toward the purposes of providing community-based treatment centers wherever they are wanted and the expansion of such facilities now in existence in a town or city if the community desires such an expansion. The amendment would provide a flexible program to meet a variety of needs. It would enable the Secretary of Health, Education, and Welfare to make grants to the State health agency, the State mental

health agency, and the State public welfare agency of any State and (with the consent of such State agency) to the health agency, mental health agency, and public welfare agency, respectively, of any political subdivision of the State, and to any public or nonprofit private agency or institution. Under these grants appropriate agencies could establish projects to develop community centers for children. Such centers would maintain continuing relationships with the schools, social agencies, courts, and other community agencies serving children and provide, or cause to be provided, continuing protective services for children served by the center.

Projects might include the cost of diagnostic and treatment services, payment for services in established community facilities, counseling services to parents and children, program research and evaluation, establishment of an advisory committee to the project and such other costs as the Secretary may determine to be reasonable. Up to 75 percent of the cost of these projects could be borne by the Federal Government.

(iii) Health study of resources relating to children's emotional illness

Under the committee amendment, the Secretary of Health, Education, and Welfare, upon the recommendation of the National Advisory Mental Health Council and after securing the advice of experts in pediatrics and child welfare, is authorized to make grants for carrying out a program of research into and study of resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illnesses.

Grants can be made to a nongovernmental agency, organization, or commission, composed of representatives of leading national medical, welfare, educational, and other professional associations, organizations, or agencies active in the field of mental health of children.

2. COSTS OF IMPROVEMENTS IN MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S AND CHILD WELFARE PROGRAMS

The accompanying tables indicate by State the allotments that would be made under the maternal and child health, crippled children's and child welfare services programs under the existing authorization of $40 million for each of these programs for the fiscal year ending June 30, 1966, and the State allotments which would be made under the proposed authorization of $45 million. The differences by State shown in the tables reflects the amount of additional funds that States would receive under the provisions of the bill in fiscal year ending June 30, 1966. Differences for subsequent years would be approximately twice as large.

The total additional authorizations for the four types of grant authorized under title II, part 1, amount to $30 million additional Federal funds in the fiscal year ending June 30, 1966, and to approximately $65 million for the first full year of operation.

Grant-in-aid apportionments in maternal and child health program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Maternal and child health		
	$40,000,000	$45,000,000	Difference
United States	$31,437,500	$34,875,000	$3,437,500
Alabama	779,483	865,734	86,251
Alaska	149,804	159,397	9,593
Arizona	264,259	292,373	28,114
Arkansas	461,030	511,649	50,619
California	1,762,722	1,961,629	198,907
Colorado	286,293	317,624	31,331
Connecticut	340,077	378,997	38,920
Delaware	164,678	176,565	11,887
District of Columbia	198,589	215,702	17,113
Florida	1,032,535	1,147,248	114,713
Georgia	985,295	1,094,585	109,290
Guam	130,061	136,612	6,551
Hawaii	189,032	204,672	15,640
Idaho	178,101	192,056	13,955
Illinois	993,623	1,133,275	139,652
Indiana	755,822	839,872	84,050
Iowa	477,111	529,723	52,612
Kansas	345,657	383,593	37,936
Kentucky	737,641	819,161	81,520
Louisiana	824,480	915,823	91,343
Maine	242,840	269,101	26,261
Maryland	626,668	696,062	69,394
Massachusetts	586,978	652,442	65,464
Michigan	1,190,820	1,323,871	133,051
Minnesota	603,346	670,198	66,852
Mississippi	719,492	798,867	79,375
Missouri	603,268	670,248	66,980
Montana	181,665	196,169	14,504
Nebraska	258,374	286,494	28,120
Nevada	156,861	167,542	10,681
New Hampshire	174,243	187,603	13,360
New Jersey	635,288	719,709	84,421
New Mexico	243,571	269,990	26,419
New York	1,653,908	1,840,461	186,553
North Carolina	1,208,705	1,342,775	134,070
North Dakota	179,079	193,185	14,106
Ohio	1,412,888	1,570,915	158,027
Oklahoma	392,553	435,721	43,168
Oregon	304,995	338,293	33,298
Pennsylvania	1,516,164	1,685,715	169,551
Puerto Rico	972,363	1,079,920	107,557
Rhode Island	190,794	206,706	15,912
South Carolina	725,666	805,734	80,068
South Dakota	185,011	200,031	15,020
Tennessee	790,909	878,471	87,562
Texas	1,547,537	1,720,787	173,250
Utah	216,786	236,704	19,918
Vermont	154,081	164,334	10,253
Virgin Islands	125,337	131,160	5,823
Virginia	904,121	1,004,415	100,294
Washington	474,460	526,821	52,361
West Virginia	397,854	441,417	43,563
Wisconsin	655,027	727,738	72,711
Wyoming	149,555	159,111	9,556

[1] Under sec. 502(a) (fund A), from a total of $20,000,000, which is half of the appropriation, each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Under sec. 502(b) (fund B), from the other $20,000,000, $4,750,000 is to be used only for special projects for mentally retarded children, and $3,812,500 or 25 percent of the remaining $15,250,000 is reserved for other special projects. The remainder, $11,437,500, is apportioned so that each State receives an amount which varies directly with the number of urban and rural live births in the State and inversely with State per capita income. No State receives less than $50,000. Live births in rural areas are given twice the weight of those in urban areas.

Grants-in-aid apportionments in crippled children's program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Crippled children		
	$40,000,000	$45,000,000	Difference
United States	$32,187,500	$35,625,000	$3,437,500
Alabama	863,999	952,425	88,426
Alaska	143,592	152,228	8,636
Arizona	281,235	310,553	29,318
Arkansas	531,492	585,446	53,955
California	1,590,273	1,821,887	231,614
Colorado	289,808	320,323	30,515
Connecticut	339,915	378,811	38,896
Delaware	162,260	173,773	11,513
District of Columbia	178,877	192,951	14,074
Florida	895,936	989,710	93,774
Georgia	1,024,979	1,130,223	105,244
Guam	127,529	133,689	6,160
Hawaii	183,185	197,923	14,738
Idaho	182,774	198,310	15,536
Illinois	990,813	1,101,414	110,601
Indiana	827,619	914,137	86,518
Iowa	549,886	606,602	56,716
Kansas	391,905	432,560	40,655
Kentucky	819,461	903,031	83,570
Louisiana	810,210	893,668	83,458
Maine	223,163	245,868	22,705
Maryland	455,442	504,001	48,559
Massachusetts	538,290	607,762	69,472
Michigan	1,201,634	1,329,113	127,479
Minnesota	654,333	722,413	68,080
Mississippi	764,518	841,932	77,414
Missouri	656,958	725,952	68,994
Montana	182,364	196,976	14,612
Nebraska	284,935	314,266	29,331
Nevada	154,259	164,540	10,281
New Hampshire	172,927	186,065	13,138
New Jersey	641,273	726,617	85,344
New Mexico	236,033	260,262	24,229
New York	1,474,981	1,688,826	213,845
North Carolina	1,332,455	1,468,283	135,828
North Dakota	183,254	201,706	18,452
Ohio	1,455,230	1,609,561	154,331
Oklahoma	463,581	511,446	47,865
Oregon	315,483	348,245	32,762
Pennsylvania	1,608,841	1,778,823	169,982
Puerto Rico	964,873	1,062,703	97,830
Rhode Island	189,749	205,500	15,751
South Carolina	775,982	854,813	78,831
South Dakota	192,665	212,111	19,446
Tennessee	894,080	985,655	91,575
Texas	1,721,357	1,902,532	181,175
Utah	217,034	236,989	19,955
Vermont	154,669	165,013	10,344
Virgin Islands	123,980	129,593	5,613
Virginia	928,948	1,024,700	95,752
Washington	485,437	536,206	50,769
West Virginia	482,236	531,184	48,948
Wisconsin	720,633	795,856	75,223
Wyoming	150,156	159,804	9,648

[1] Under sec. 512(a) (fund A) each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Under sec. 512(b) (fund B) $3,750,000 is to be used only for special projects for services for crippled children who are mentally retarded, and $4,062,500 or 25 percent of the remaining $16,250,000 is reserved for other special projects. The remainder, $12,187,500, is apportioned so that each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than $50,000. Children in rural areas are given twice the weight of those in urban areas.

Grant-in-aid apportionments in child welfare services program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Child welfare services		
United States	$40,000,000	$45,000,000	Difference
Alabama	$967,555	$1,091,458	$123,903
Alaska	113,887	119,945	6,058
Arizona	429,043	478,608	49,565
Arkansas	566,938	635,538	68,600
California	2,624,224	2,976,823	352,599
Colorado	433,247	483,391	50,144
Connecticut	409,761	456,663	46,902
Delaware	132,304	140,904	8,600
District of Columbia	156,010	167,883	11,873
Florida	1,207,863	1,364,939	157,076
Georgia	1,131,739	1,278,307	146,568
Guam	93,590	96,847	3,257
Hawaii	206,836	225,726	18,890
Idaho	234,833	257,587	22,754
Illinois	1,553,967	1,758,822	204,855
Indiana	973,197	1,097,879	124,682
Iowa	606,419	680,469	74,050
Kansas	496,926	555,861	58,935
Kentucky	829,251	934,061	104,810
Louisiana	981,196	1,106,982	125,786
Maine	283,552	313,031	29,479
Maryland	641,585	720,489	78,904
Massachusetts	840,093	946,401	106,308
Michigan	1,596,422	1,807,138	210,716
Minnesota	782,091	880,392	98,301
Mississippi	745,712	838,991	93,279
Missouri	826,711	931,172	104,461
Montana	221,229	242,105	20,876
Nebraska	351,869	390,780	38,911
Nevada	122,354	129,581	7,227
New Hampshire	193,094	210,087	16,993
New Jersey	991,052	1,118,199	127,147
New Mexico	337,936	374,923	36,987
New York	2,346,004	2,660,195	314,191
North Carolina	1,263,503	1,428,261	164,758
North Dakota	220,182	240,914	20,732
Ohio	1,906,641	2,160,181	253,540
Oklahoma	589,610	661,340	71,730
Oregon	399,676	445,186	45,510
Pennsylvania	2,026,983	2,297,136	270,153
Puerto Rico	912,601	1,028,918	116,317
Rhode Island	224,624	245,969	21,345
South Carolina	782,123	880,428	98,305
South Dakota	236,471	259,452	22,981
Tennessee	972,161	1,096,700	124,539
Texas	2,383,790	2,703,198	319,408
Utah	311,639	344,997	33,358
Vermont	156,067	167,948	11,881
Virgin Islands	83,928	85,851	1,923
Virginia	1,026,137	1,158,128	131,991
Washington	598,485	671,440	72,955
West Virginia	478,560	534,959	56,399
Wisconsin	863,453	972,985	109,532
Wyoming	134,876	143,832	8,956

[1] Under sec. 522(a) each State receives a uniform grant of $70,000 and an additional grant which varies directly with the number of children under 21 years in the State and inversely with State per capita income.

C. Implementation of Mental Retardation Planning

Under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88–156), $2.2 million was authorized to provide small grants to States for the purpose of planning comprehensive programs in the field of mental retardation. The requirements for receipt of such grants included the involvement of all types of agencies—health, education, welfare, institutions, etc.—concerned with problems of the mentally retarded. The committee is advised that each State has submitted an application and received a grant under this program.

In order to assure that the planning which is being done has impact on State programs, the committee believes that further limited grants for purposes of followup and implementation are warranted. The bill accordingly authorizes appropriations of $2,750,000 each for the fiscal years ending June 30, 1966, and June 30, 1967, for this purpose. Each of these appropriations would be available for expenditure for the fiscal year for which it was made and for succeeding fiscal years that end prior to July 1, 1968.

D. Old-Age, Survivors, and Disability Insurance Provisions

(1) SEVEN-PERCENT INCREASE IN BENEFITS

The committee believes that the need for a benefit increase at this time is obvious. The last general benefit increase was enacted in 1958 and was effective with benefits payable for January 1959. Since that date there have been changes in wages, prices, and other aspects of the economy.

Under the bill monthly benefits for retired workers now on the benefit rolls who began to draw benefits at age 65 or later would range from $44 to $135.90, as compared with $40 to $127 under present law. Because of the increases that the bill would make in the contribution and benefit base, retired workers coming on the rolls in the future with benefits based on average monthly earnings of more than $400, the highest possible under present law, would of course get benefits of nore than $135.90. The increase in the base, together with the benefit increase, would result in a maximum benefit for the worker of $168, payable on average monthly earnings of $550 (the highest possible under the $6,600 contribution and benefit base). The following table is illustrative of benefit amounts for various family groups under the $6,600 contribution and benefit base and under present law.

Illustrative monthly benefits payable under present law and under the committee bill with a $6,600 contribution and benefit base

Average monthly earnings	Old-age benefits [1]				Survivors benefits			
	Worker		Man and wife [2]		Widow aged 62, widower, or parent		Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Present law	Bill [3]
$67 or less	$40	$44.00	$60.00	$66.00	$40.00	$44.00	$60.00	$66.00
$100	59	63.20	88.50	94.80	48.70	52.20	88.50	94.80
$150	73	78.20	109.50	117.30	60.30	64.60	120.00	120.00
$200	84	89.90	126.00	134.90	69.30	74.20	161.70	161.70
$250	95	101.70	142.50	152.60	78.40	83.90	202.50	202.50
$300	105	112.40	157.50	168.60	86.70	92.80	236.40	240.00
$350	116	124.20	147.00	186.30	95.70	102.50	254.10	279.60
$400	127	135.90	190.50	203.90	104.80	112.20	254.10	306.00
$450	(4)	146.00	(4)	219.00	(4)	120.50	(4)	328.20
$500	(4)	157.00	(4)	235.50	(4)	129.60	(4)	348.60
$550 [5]	(4)	168.00	(4)	252.00	(4)	138.60	(4)	368.00

[1] For a worker age 65 or over at the time of retirement and a wife age 65 or over at the time when she comes on the rolls.

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

[3] For families already on the benefit rolls who are affected by the maximum-benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.

[4] Not applicable, since the highest possible average monthly earnings amount is $400.

[5] The maximum under the $6,600 contribution and benefit base that the committee recommends go into effect in 1966.

The family maximum.—Under the bill, the maximum amount of benefits payable to a family would be related to the worker's average monthly earnings through the entire range of average monthly earnings as it now is at the lower levels. Under present law, the highest maximum family benefit is $254, and this amount applies at all average monthly earnings levels above $314. Under the bill, a different family maximum amount would be provided at every average monthly earnings bracket in the benefit table, from a minimum of $66 to a maximum of $368. The maximum amount payable to a family now on the benefit rolls would be $309.20, as compared with $254 under present law.

Effective date.—The 7-percent increase would be effective beginning with benefits for January 1965. The increased benefits would be paid retroactively to the 20 million beneficiaries who were on the rolls in January 1965 and to beneficiaries who came on the rolls after January 1965 and through the month of enactment of the bill whether or not they are still on the rolls at the time of enactment. Lump-sum death payments based on deaths that occurred in the retroactive period (before the month of enactment) would not be increased.

This is the first time that a general increase in social security benefits has been made retroactive. The present situation may be regarded as somewhat unique. H.R. 11865, as passed by both Houses last year, provided for a general benefit increase and, if the bill had been enacted, it would have provided increased social security benefits that would have been effective at about the beginning of 1965. For reasons not related to the question of whether benefits should be increased, H.R. 11865 failed of passage last year. The committee therefore recommends paying the increased benefits retroactively to January, thus putting beneficiaries in the same relative position they would have been in if H.R. 11865 had been enacted.

Because of the magnitude of the task of converting the benefit rolls to the higher amounts, the first regular monthly check reflecting the 7-percent increase generally would be the check for the third month following the month of enactment.

To avoid the possibility of confusion on the part of beneficiaries as to the exact amount of the benefit increase, the increased benefits for the retroactive months would be paid in a separate check.

In 1965, an estimated $1.2 billion in additional benefits would be paid as a result of the 7-percent increase; in 1966, $1.5 billion in additional benefits would be paid.

2. PAYMENT OF CHILD'S INSURANCE BENEFITS TO CHILDREN ATTENDING SCHOOL OR COLLEGE AFTER ATTAINMENT OF AGE 18 AND UP TO AGE 22

Under present law a child beneficiary is considered dependent, and is paid benefits, until he reaches age 18, or after that age if he was disabled before age 18 and is still disabled. The committee believes that a child over age 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and that it is not realistic to stop such a child's benefit at age 18. A child who cannot look to a father for support (because the father has died, is disabled, or is retired) is at a disadvantage in completing his education as compared with the child who can look to his father for support. Not only may the child be prevented from going to college by loss of

parental support and loss of his benefits; he may even be prevented from finishing high school or going to a vocational school. With many employers requiring more than a high school education as a condition for employment, education beyond the high school level has become almost a necessity in preparing for work.

The committee believes it is now appropriate and desirable to provide social security benefits for children between the ages of 18 and 22 who are full-time students and who have suffered a loss of parental support. Students whose benefits have already terminated at age 18, as well as children currently on the rolls, would qualify for benefits under the provision. The median age of students graduating from high school is about 18; providing benefits up to age 22 would mean that for many children benefits could continue for the time it takes to complete a 4-year college course.

The term "school" is defined broadly to permit payments to students taking vocational or academic courses. The definition of school is intended to establish that the institution the child attends is a bona fide school. It includes all public schools, colleges, and universities, as well as private, accredited institutions and private nonaccredited institutions whose credits are accepted by accredited institutions. In determining full-time attendance, the Secretary of Health, Education, and Welfare would take into account the standards and practices of the school involved. Specifically excluded would be an individual paid by his employer to attend school. Benefits would be paid during normal school vacation periods as well as during the school year.

The bill would not provide for the payment of mother's benefits to a mother whose only child is over 18 and getting benefits because he is attending school. There is less need to pay benefits to the mother in such cases than in those where the child is under 18, since she is not required to stay at home to care for the child as she may have been when he was younger.

The provision for paying benefits to children aged 18 to 21 who are full-time students would be effective beginning with benefits for January 1965. Benefits would be paid retroactively to children who would have been eligible in January 1965 and to those who have become eligible since that time regardless of whether they are eligible in the month in which the bill is enacted. A provision similar to this was included in H.R. 11865, 88th Congress, which failed of passage for reasons entirely unrelated to the payment of benefits to children aged 18 to 21 who were full-time students. The committee recognizes that the retroactive benefit payments cannot be made immediately after this bill is enacted since there may be some delay because of administrative problems.

An estimated 295,000 children would be eligible for benefits for September 1965, when the school year begins, and in 1966 about $195 million in benefits would be paid.

3. BENEFITS FOR WIDOWS AT AGE 60

Under present law the earliest age at which a widow without eligible children can qualify for benefits based on the earnings of her deceased husband is 62. Many women are widowed years after having left the labor market to become housewives and mothers, and they lack the skills necessary to qualify for reasonably suitable employment.

Women who are widowed in their late fifties and sixties are often denied employment because of their age.

The bill would provide for the payment of aged widow's benefits beginning at age 60, with the benefits actuarially reduced to take account of the longer period over which they would be paid. This provision would thus extend to these women a choice of applying for benefits at any time between age 60 and 62, with a reduced benefit, or of waiting until age 62 to receive a full widow's benefit. The amount of the reduction—five-ninths of 1 percent for each month before age 62 for which the benefit was paid—would be sufficient to assure that over the long run there will be no additional cost to the social security system as a result of the earlier payment of the benefits. If the widow chose to get her benefits starting at age 60, her benefit would be reduced by 13⅓ percent; the reduced benefit would amount to 71½ percent of the deceased husband's primary benefit (at age 62 the full benefit equals 82½ percent of the deceased husband's primary insurance benefit).

An estimated 185,000 widows aged 60 and 61 on the effective date of this provision are expected to claim benefits during the first year of operation. Benefit payments would be about $165 million in 1966.

4. AMENDMENTS OF DISABILITY PROGRAM

The Social Security Amendments of 1956 extended the insurance protection of the social security program to provide monthly benefits for persons with disabilities of long-continued and indefinite duration and of sufficient severity to prevent a return to any substantial gainful work. In providing this protection against loss of earnings resulting from extended total disability, the Congress designed a conservative program. Amendments enacted in 1958 and 1960 liberalized the disability program, among other changes, extended benefits to wives and children of the disabled, and provided for the payment of benefits to disabled workers under age 50, who had previously been excluded. All the recommended changes in the disability provisions of the program would be adequately financed from the contributions the committee is recommending be earmarked for the disability insurance trust fund.

(*a*) *Elimination of the long-continued and indefinite duration requirement from the definition of disability*

Under present law, disability insurance benefits are payable only if the worker's disability is expected to result in death or to be of long-continued and indefinite duration. The House bill would broaden the disability protection afforded by the social security program by providing disability insurance benefits for an insured worker who has been totally disabled throughout a continuous period of 6 calendar months. The committee believes that the House provision could result in the payment of disability benefits in cases of short-term, temporary disability. Under the House provision, for example, benefits could be paid for several months in cases of temporary disability resulting from accidents or illnesses requiring a limited period of immobility. The committee believes, therefore, that it is necessary to require that a worker be under a disability for a somewhat longer period than 6 months in order to qualify for disability benefits. As a result, the committee's bill modifies the House bill to provide for

the payment of disability benefits for an insured worker who has been or can be expected to be totally disabled throughout a continuous period of 12 calendar months. (Disability insurance benefits would also be payable if disability ends in death during this 12-month period, provided the worker has been disabled throughout a waiting period of 6 calendar months prior to death.) The effect of the provision the committee is recommending is to provide disability benefits for a totally disabled worker even though his condition may be expected to improve after a year. As experience under the disability program has demonstrated, in the great majority of cases in which total disability continues for at least a year the disability is essentially permanent. Thus, where disability has existed for 12 calendar months or more, no prognosis would be required. Where a worker has been under a disability which has lasted for less than 12 calendar months, the bill would require only a prediction that the worker's disability will continue for a total of at least 12 calendar months after onset of the disability.

The House bill modifies the provision of present law under which the waiting period is waived in subsequent disability so as to make this provision more restrictive when applied to short-term disabilities. Since, under the definition the committee is recommending, disability protection would be limited to workers with extended total disabilities the same test of disability initially applied should also be applicable in second and subsequent disabilities. Under the provision in the committee bill, benefits would be paid beginning with the first month of onset of the second or subsequent disability and without regard to the waiting period requirement if the individual is under a disability which occurred within 5 years of the termination of his previous disability and which can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 calendar months.

The modification in the definition of disability recommended by the committee does not change the requirement in existing law that an individual must by reason of his impairment be unable "to engage in any substantial gainful activity."

An individual with a disabling impairment which is amenable to treatment that could be expected to restore his ability to work would meet the revised definition if he is undergoing therapy prescribed by his treatment sources, but his disability nevertheless has lasted, or can be expected to last, for at least 12 calendar months. However, an individual who willfully fails to follow such prescribed treatment could not by virtue of such failure qualify for benefits.

The committee expects that, as now, procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical examinations and work activity will be obtained where appropriate so that benefits may be terminated promptly where the worker ceases to be disabled.

The committee retains the provision in present law under which payment of disability benefits is first made for the seventh full month of disability. The House bill would have authorized payments beginning with the sixth full month of disability.

It is estimated that if benefits were payable for disabilities that are total and last more than 12 calendar months but are not necessarily expected to last indefinitely, about 60,000 additional people—workers

and their dependents—would become immediately eligible for benefits. Benefit payments under the provision in 1966 would total $40 million.

(*b*) *Reduction of disability benefits on account of receipt of workmen's compensation benefits*

The committee has taken note of the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits payable under State workmen's compensation programs. While data of the kind requested by the House Committee on Ways and Means in its report on this bill are not now available, the committee believes that amendatory legislation should not await completion of the requested study. Although there is some dispute as to the number of workers who receive benefits under these two programs and whether these payments are excessive, the committee believes that it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits.

The committee believes that the provision it is recommending avoids the problems and inequities of the earlier offset provision in the social security law for reducing monthly disability benefits by the amount of any other benefit to which a worker was entitled under State workmen's compensation laws, which was in effect from July 1957 to July 1958, but was repealed then. The new offset provision recommended by the committee provides for a reduction in the social security disability benefit (except where the State workmen's compensation law provides for an offset against social security disability benefits) in the event the total benefits paid under the two programs exceed 80 percent of the worker's average monthly earnings prior to the onset of disability. Under this provision, the worker's average monthly earnings would be defined as the higher of (*a*) his average monthly wage used for purposes of computing his social security disability benefit or (*b*) his average monthly earnings, in employment covered by social security, during his highest 5 consecutive years after 1950. (In no event, however, would the total benefits payable with respect to a worker be reduced below the amount of the unreduced monthly social security benefits.) This reduction formula would generally avoid the inequity encountered under the previous offset provision, where the reductions that were required frequently resulted in benefits that replaced no more than 30 percent or so of the worker's earnings at disablement.

The offset provision the committee is recommending is also designed to minimize certain other inequities previously encountered. In order to overcome, in part, the erosion in the earnings replacement value of disability benefits that occurs over time with increases in wage levels and living costs, the reduction itself will be automatically redetermined periodically to take into account increases in the level of earnings.

The following is an illustrative example of how this provision operates. Let us assume that a worker is disabled in an occupational accident in a certain future year and that he has a wife and one child under age 18. His workmen's compensation benefit is $48 a week, which is $208 on a monthly basis.

His "average monthly wage" that is used to compute his disability insurance benefit is $420, and so his primary insurance amount is $140. Accordingly, his monthly benefits, before reduction, are $140 for himself, $70 for his wife, and $70 for his child—a total of $280.

His covered wages in his highest 5 consecutive years totaled $27,000, or a monthly average of $450. Since the latter is higher than his "average monthly wage," it is used as his "average covered earnings."

The monthly maximum initially applicable to his combined disability insurance and workmen's compensation benefits is then 80 percent of $450, or $360. (If his unreduced disability benefit was larger than the figure derived by the 80-percent rule, then such amount would be used instead of $360; as a result, the aggregate disability insurance and workmen's compensation benefit would equal the unreduced disability benefit, and so the reduction in the disability benefit would be the amount of the workmen's compensation benefit.) Since the total of his workmen's compensation benefit and his unreduced disability benefits is $488, his disability benefits must be reduced by $128. Accordingly, since the reduction is first applicable to the supplementary benefits, the reduced disability benefits are as follows: worker—$140; wife—$6; and child—$6 (a family total of $152 for disability insurance and of $360 for both programs combined).

Next, let us assume that a general benefit increase is legislated for all social security beneficiaries in the next year and that this worker's primary insurance amount is increased by $10 (to $150), which in turn would increase the wife's benefit by $5 (to $11) and the child's benefit by $5 (to $11). These increases are passed on to the beneficiary and his family, despite the 80-percent limitation.

Finally, let us consider the effect of the triennial redetermination of the 80-percent limitation. Let us suppose that the average of the taxable wages of all persons for whom taxable wages were reported in the first calendar quarter of the year in which he was disabled was $1,200 and that such average for the second following year was $1,320, or 10 percent higher. It should be noted that this average first quarter taxable wage largely eliminates the dampening effect of the earnings base and so is quite accurately indicative of the wage level in covered employment; the average is based on the number of wage reports received and on the total taxable wages therein.

Accordingly, the "80 percent of average covered earnings" limitation is increased, effective for January of the next year, from $360 to $396 per month. Thus, the family disability insurance benefit has a monthly maximum of $188 (i.e., $396, minus the $208 workmen's compensation benefit). The disabled worker receives the full primary insurance amount of $150 (including the $10 increase by the legislative across-the-board increases after initial determination), and the wife and child each receive $19 per month.

If the redetermination of the "80 percent of average covered earnings" limitation had been such as to increase the total of the workmen's compensation benefit and the family disability insurance benefit from the initial $360 per month by $20 or less ($20 being the amount of the previous across-the-board legislative increase in the disability benefits for the family), the disability insurance benefit amounts payable would be unchanged—at $150 for the worker and $11 each for the wife and child (reflecting only the legislative across-the-board increases after the initial determination).

The recommended provision by the committee also authorizes the Secretary to make payment of social security disability benefits even where a workmen's compensation proceeding is pending. The reduction will be applicable prospectively upon notification by the worker,

employer, carrier, or State agency, as provided in regulations, that a workmen's compensation award has been made. This would eliminate what proved to be a source of serious delay under the previous offset provision under which the social security award had to be held up pending investigation of the possibility of a workmen's compensation award not only in cases where an offset was required but also in many cases where it was not.

(c) *Payment of child's insurance benefits to children disabled before reaching age 22*

Under present law, an individual is considered dependent, and is paid child's insurance benefits, if he has been continuously disabled since before age 18. However, the individual who becomes disabled between the ages of 18 and 22 ordinarily would not have worked the 5 years necessary to be eligible for disability protection based on his earnings. Moreover, even in the case of an individual who was working the likelihood is that in the event he became disabled before age 22 his parent would once again assume full financial responsibility for his support. The committee believes, therefore, that it is now appropriate and desirable to provide social security benefits for an individual disabled before age 22 should his parent die, become disabled or retire.

Benefits payable by reason of this change would be paid for the second month following the month of enactment. It is estimated that about 20,000 persons (disabled children and their mothers) would become immediately eligible for benefits under these provisions. Benefit payments under these provisions would total $10 million in 1966.

(d) *Payment of disability insurance benefits after entitlement to other monthly insurance benefits*

Under the hospital insurance benefit provisions of the committee's bill, a wife who is age 65 or over and whose husband is between the age of 62 and 65 and is fully insured can qualify for hospital insurance, provided her husband files for actuarially reduced old-age insurance benefits. The husband may be working full time and not receive any of the old-age benefits. Under present law, he would be reluctant to file for old-age benefits because present law states that after a worker becomes entitled to old-age benefits; he cannot subsequently qualify for disability benefits. If present law were unchanged, the worker would be faced with the choice of sacrificing either eligibility for disability protection or his wife's hospital insurance.

The committee has, therefore, included in the bill a provision whereby a worker who becomes entitled to old-age benefits before age 65 may subsequently, until he reaches age 65, become entitled to disability benefits. This provision would also eliminate the difficult question some beneficiaries have faced, even before the hospital insurance problem arose, as to whether they should take actuarially reduced benefits or retain their rights to disability protection.

(e) *Increase in allocation to the disability insurance trust fund*

H.R. 6675 as passed by the House would have increased the contribution income allocated to the disability insurance trust fund from 0.50 to three-fourths of 1 percent of taxable wages and from 0.375 to nine-sixteenths of 1 percent of taxable self-employment in-

come. This increase was to take account both of lower disability termination rates than were expected (disability insurance beneficiaries have been living somewhat longer than anticipated) and the increase in the cost of the disability insurance part of the program arising out of the changes made by the bill. Under the bill as modified, the increase in the cost of the disability insurance program will be less than that anticipated under the House bill, and the committee therefore recommends a somewhat smaller increase in the allocation to the disability insurance trust fund: to 0.70 percent of taxable wages and to 0.525 percent of taxable self-employment income. This increase in the contribution income to the disability fund would bring the disability insurance part of the program into close actuarial balance.

(f) Payment from the trust funds for costs of vocational rehabilitation services furnished to disability insurance beneficiaries

One of the objectives of the social security disability program is to promote the rehabilitation of disability insurance beneficiaries. The present law declares it to be the policy of the Congress that applicants for disability insurance benefits be referred to the State vocational rehabilitation agencies for vocational rehabilitation services with the objective of restoring as many as possible to productive activity. Pursuant to this provision, arrangements have been established whereby the medical and vocational information in social security records of applicants are made available to the State vocational rehabilitation agencies for consideration for rehabilitation services.

Although these arrangements have facilitated the rehabilitation of a number of social security disability beneficiaries, the number who are receiving rehabilitation services remains small and only about 3,000 are rehabilitated annually at present. The limitations on facilities and services resulting from the fact that most States fall short of matching the Federal funds available for vocational rehabilitation constitute substantial obstacles to the rehabilitation of a greater number of social security beneficiaries. Under present conditions the States are not able to provide services for all handicapped people who apply and can benefit from them. It is natural that they give priority to applicants for such services who have the best rehabilitation potential. Social security disability beneficiaries, who are likely to be older and more severely disabled than other applicants for vocational rehabilitation, generally do not represent the best investment of the State's rehabilitation resources, and they often have a lower priority than others applying for rehabilitation services.

With the objective of making it possible for more disability insurance beneficiaries to receive vocational rehabilitation services, the committee is recommending that money be made available from the social security trust funds to finance the rehabilitation of selected disability beneficiaries. The money so used will be allocated, under the provision the committee is recommending, in such a way that the saving from the amount of benefits that would otherwise have to be paid and the increased contributions to the trust funds paid on the earnings of beneficiaries who return to work would exceed, or at least equal, the money paid from the trust funds for rehabilitation costs.

The committee believes that such an expenditure from the trust funds is justified because of the offsetting gains to those funds as well

as the gains that would flow to the individual concerned and to society when disabled people are returned to gainful work. In order to achieve savings to the trust funds that will at least offset rehabilitation expenditures from those funds, the committee expects that there will be continuing evaluation of the effects of the rehabilitation expenditures and that appropriate adjustments will be made, as necessary, in selection criteria.

Under the recommended provision, the services that would be reimbursable are those that are provided under a State plan for vocational rehabilitation services which has been approved under the Vocational Rehabilitation Act and which provides that services would be furnished to qualified individuals in accordance with criteria approved by the Social Security Administration and the Vocational Rehabilitation Administration and without regard to the individual's citizenship, residence, or need for financial assistance. The Secretary is authorized to provide such rehabilitation services for persons in any State which does not have a plan meeting the above requirements by means of agreements or contracts with other public or private agencies. However, the total amount of the funds that may be made available from the trust funds for purposes of reimbursing State agencies for vocational rehabilitation services could not, in any year, exceed 1 percent of the social security disability benefits paid in the previous year.

(*g*) *Facilitating disability determinations*

The committee believes that there are a number of disability cases in which the existence of long-lasting disability can be readily established, and the claim for disability insurance benefits promptly adjudicated, without the need for obtaining new medical evidence. Similarly, there are cases where it would appear that entitlement to disability benefits could be more promptly terminated on the basis of evidence received by the Secretary that the beneficiary has either recovered or returned to gainful work. Under present law, however, disability determinations, including determinations that a disabled person has recovered, generally must be made by State agencies under agreements with the Secretary. To speed up the disability determination process, both with respect to initial adjudication of claims for benefits and to the termination of entitlement to benefits, the committee believes that the requirement that disability determinations be made by State agencies should be made more flexible. The committee is recommending, therefore, that the Secretary be authorized to make disability determinations directly in those cases which can be promptly adjudicated on the basis of readily available medical and other evidence furnished by or on behalf of the applicant from existing sources of information and to terminate entitlement to disability benefits in cases of recovery based on such evidence or on evidence received by the Secretary that a beneficiary has returned to gainful work. This provision would enable the Secretary to utilize improvements in procedures and in the participation of the medical profession in providing evidence under the program to the end that determinations in clear-cut cases can be made with maximum speed and soundness.

Under the provision recommended by the committee, State agencies would continue, as under present law, to be fully utilized to handle

the increasing volume of claims that usually require the purchase of independent medical and vocational evidence needed for proper determinations. This would apply to both initial disability determinations as well as to subsequent reinvestigations of possible recovery cases. The provision recommended by the committee does not contemplate that any changes will be made in the role played by the State agencies in the handling of cases requiring further development.

5. PAYMENT OF BENEFITS TO CERTAIN PEOPLE AGED 72 OR OVER WHO ARE NOT OTHERWISE INSURED

The committee believes that a special transitional insured status provision should be adopted so that social security benefits can be provided for those among the present aged who, though they worked in covered jobs, did not have an opportunity to work long enough to become insured under the program, and for their wives and widows. About 355,000 people would become eligible immediately for social security benefits under these provisions, with benefits payable under the provisions totaling about $140 million in 1966.

The present law requires a minimum of six quarters of coverage for insured status; as a result, although the general requirement for insured status is one quarter of coverage for each year elapsing after 1950 and up to retirement age (65 for men, 62 for women), people who reached retirement age in 1956 or earlier must have more than one quarter for each year that elapsed after 1950 to qualify for benefits.

Under the bill the minimum would be three quarters of coverage rather than six, and therefore people who reached retirement age in 1954, 1955, or 1956 could qualify for benefits if they had one quarter of coverage for each year that elapsed after 1950 and up to retirement age, and people who reached retirement age prior to 1954 could qualify if they had three quarters of coverage instead of six.

The following table shows the operation of the "transitional insured status" provision for workers:

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

Wife's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969.

Widow's benefits would be payable at age 72 to a woman whose husband dies after the transitional provisions go into effect if she reached age 72 before 1969 and if her husband could have qualified for benefits (or did qualify) under the transitional provisions. Widow's benefits would also be payable to a widow whose husband died before the provisions went into effect if she reached age 72 before 1969 and if her husband died or reached age 65 before 1957. Such a widow

could get benefits if her husband had a specified number of quarters of coverage, as shown in the following table:

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

Under these provisions the benefit amount for a worker would be $35 per month; for his wife, $17.50 per month; for his widow, $35 per month. Benefits would be payable for and after the second month following the month of enactment.

6. LIBERALIZATION IN THE RETIREMENT TEST

The bill would liberalize the retirement test so that a beneficiary under age 72 could earn $1,800 in a year without any reduction in his benefit amount. If his earnings exceeded $1,800, $1 in benefits would be withheld for each $2 of earnings between $1,800 and $3,000 and for each $1 of earnings thereafter. (Under present law, the amount a beneficiary under age 72 may earn in a year without any reduction in benefits is $1,200. If his earnings exceed $1,200, $1 in benefits is withheld for each $2 in earnings between $1,200 and $1,700 and for each $1 of earnings thereafter.) Also, the bill would raise from $100 to $150 the amount of earnings a beneficiary may have in a month and get full benefits for that month regardless of his annual earnings.

The House bill did not raise the amount a beneficiary could earn in a year without any reduction in his benefits. It did, however, liberalize the retirement test by raising the uppermost limit on the amount of earnings to which the $1 reduction in benefits for each $2 of earnings applies from $1,700 to $2,400.

The $1,200 annual exempt amount of earnings under present law was set in 1954. Since that time wages have risen substantially. An $1,800 exemption now seems a reasonable measure of the amount of work a person can do and still be considered substantially retired.

In addition to liberalizing the annual exempt amount of earnings, the committee's bill improves the operation of the retirement test in relation to incentives to work. Under the present test, if a social security beneficiary has a choice between taking a job paying $1,700 or slightly less, and taking one paying somewhat more than $1,700 but not a great deal more, he may be less well off if he takes the higher paying job, because he loses a dollar in tax-free benefits for every dollar he gets in taxable earnings above $1,700. By moving this point up to $3,000, the bill would do much to lessen the deterrent for beneficiaries to work.

Under present law a self-employed person who performs substantial services but who has no income from current work can nevertheless have benefits withheld under the retirement test because he gets royalties attributable to a copyright or patent obtained in years before he attained age 65. The bill would exclude for retirement test pur-

poses royalties received by a self-employed person in or after the year in which he attained age 65 if those royalties are attributable to a copyright or patent obtained before the year in which he attained age 65. Royalties received by a beneficiary from a copyright or patent obtained in or after the year in which he attained age 65 would continue to be counted for retirement test purposes, as under present law, in the year in which they are received.

7. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

It is not uncommon for a marriage to end in divorce after many years, when the wife is too old to build up a substantial social security earnings record even if she can find a job. But under present law a wife's right to benefits on her husband's earnings record generally ends with a divorce. Under the present social security law, the only benefits provided for a divorced woman are mother's insurance benefits, and they are payable only if she has a child of the deceased worker in her care and the child is getting benefits on the basis of his deceased father's earnings, if she has not remarried, and if she had been getting at least one-half of her support from her former husband under a court order or agreement at the time of his death. A divorced wife without a child in her care cannot get benefits even though she had been dependent upon the worker for much of his working lifetime and he was contributing to her support when he retired or died.

Under the bill, wife's or widow's benefits would be payable to an aged divorced woman on the basis of her former husband's earnings if the divorced woman (A) had been married to that former husband for 20 years before the divorce, (B) was not remarried, and (C) met the following support requirement at the time her former husband became disabled, became entitled to benefits or died; (1) she was receiving one-half of her support from her former husband, or (2) she was receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions to her support from her former husband was in effect. A conforming change would be made in the support requirements that must be met by a former wife divorced (renamed "surviving divorced mother" in the bill) in order to qualify for mother's benefits based on the social security account of her deceased former husband. (The provisions of present law for paying mother's and widow's benefits to women who have not remarried are also amended by the committee bill to provide for the payment of these benefits to women who are not married regardless of a remarriage which has terminated.)

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

The bill would also provide that a wife's benefit will not terminate when she and her husfand are divorced if they had been married for at least 20 years before the divorce.

Benefits for a divorced wife or a surviving divorced wife would not terminate on account of remarriage in those cases where widow's benefits under present law do not terminate—that is, where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving di-

vorced wife married an old-age insurance beneficiary, her benefits would terminate but she would immediately be eligible for wife's benefit on her new husband's account.

While the provisions just described would take care of cases in which the marriage had lasted for 20 years or more, they would leave unsolved the problem of the woman who is widowed or divorced after many years and is remarried but whose second marriage ends in death or divorce, leaving the woman with no social security benefit rights based on either her first or her second husband's earnings. To meet this problem, the House bill provided that a woman whose rights to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried will have her former benefit rights restored if her second marriage ends in divorce after less than 20 years.

The committee believes that this provision would be unduly complex and restrictive and we have therefore simplified and extended it so that in any case where an aged divorced wife, widow, or surviving divorced wife is not married at age 62 or over (age 60 in the case of widow's insurance benefits) she will have whatever rights to benefits she has ever had, regardless of intervening marriages which have ended in death, divorce, or annulment. Of course, under the provisions of existing law relating to simultaneous entitlement to more than one auxiliary benefit, she would get only one benefit—the highest of the benefits to which she could be entitled. Young women getting mother's benefits (including surviving divorced mothers) would also have protection in case their second marriages ended in death or divorce.

These changes would provide protection mainly for women who have spent their lives in marriages that are dissolved when they are far along in years—especially housewives who have not been able to work and earn social security benefit protection of their own—from loss of benefit rights.

8. ADOPTION OF CHILD BY RETIRED WORKER

Under present law, a child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits even though he was not dependent on the worker at the time the latter retired. In contrast, present provisions governing the payment of child's insurance benefits to a child adopted by a person getting disability insurance benefits, and to a child adopted by the surviving spouse of a worker who has died, contain requirements designed to assure that benefits will be paid to such children only when there is a basis for assuming that the child lost a source of support when the worker became disabled or died.

The committee believes that the provisions concerning adoptions by retired workers should be made comparable to those relating to adoptions in other cases so as to provide safeguards against abuse through adoption of children solely to qualify them for benefits, and has included in the bill a provision that would accomplish this result. Under this provision benefits would be payable to a child who is adopted by an old-age insurance beneficiary after the latter becomes entitled to benefits only if the following conditions are met:

(1) At the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun;

(2) The adoption was completed within 2 years of the time when the worker became entitled to benefits; and

(3) The child had been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or, if the worker had a period of disability which continued until he became entitled to old-age insurance benefits, before the beginning of the period of disability.

9. CONTINUATION OF WIDOW'S AND WIDOWER'S INSURANCE BENEFITS AFTER REMARRIAGE

Under the present social security law, widow's and widower's benefits based on a deceased worker's social security earnings record generally stop when the survivor remarries. The committee believes that this provision has an undesirable result in that widows (and widowers) who would like to remarry do not do so because if they did they would lose their social security benefits.

On the other hand, we recognize that if a widow who remarried continued to get benefits at the widow's percentage (82½ percent of a worker's benefit amount), and did not have her benefits recomputed according to the percentage paid to a wife (50 percent of a worker's benefit amount), the widow and her new husband would receive substantially more, as a rule, than she and her previous husband had received and substantially more, as a rule, than her new husband and any previous wife had received. Moreover, the couple would be receiving more than other couples would get where the husbands had an identical record of covered earnings.

The committee has therefore added a new provision under which benefits would be payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit would be 50 percent of the primary insurance amount of the deceased spouse plus the excess, if any, of the wife's or husband's benefit based on the earnings record of the new spouse.

The 50-percent benefit would not be subject to actuarial reduction regardless of the age of the widow and regardless of prior receipt of any reduced benefit; if in some later month the widow was not married (because her second husband died or they were divorced); she would get an 82½-percent benefit, and months in which the 50-percent benefit had been paid to her prior to age 62 would be counted in figuring the reduction in her 82½-percent benefit.

10. DEFINITION OF CHILD

Under present law, whether a child meets the definition of a child for the purpose of getting child's insurance benefits based on his father's earnings depends on the laws applied in determining the devolution of intestate personal property in the State in which the worker is domiciled. The States differ considerably in the requirements that must be met in order for a child born out of wedlock to have inheritance rights. In some States a child whose parents never married can inherit property just as if they had married; in others such a child can inherit property as the child of the man only if he was acknowledged or decreed to be the man's child in accordance

with requirements specified in the State law; and in several States a child whose parents never married cannot inherit his father's intestate property under any circumstances. As a result, in some cases benefits must be denied where a child is living with his mother and father in a normal family relationship and where neither the child nor his friends and neighbors have any reason to think that the parents were never married.

The committee believes that in a national program that is intended to pay benefits to replace the support lost by a child when his father retires, dies, or becomes disabled, whether a child gets benefits should not depend on whether he can inherit his father's intestate personal property under the laws of the State in which his father happens to live. The committee has therefore included in the bill a provision under which benefits would be paid to a child on the earnings record of his father, even though the child cannot inherit the father's intestate property, if the father had acknowledged the child in writing, had been ordered by a court to contribute to the child's support, had been judicially decreed to be the child's father, or is shown by other evidence satisfactory to the Secretary of Health, Education, and Welfare to be the child's father and was living with or contributing to the support of the child.

11. DEFINITION OF WIFE, WIDOW, HUSBAND, AND WIDOWER

Under a new provision added by the committee, a person who is eligible for one of certain survivor annuities under the Railroad Retirement Act and who marries a worker insured under social security would be accorded the same treatment with respect to the eligibility requirements for wife's, husband's, widow's, or widower's benefits under social security as present law now gives people who at the time of their marriage were eligible for certain social security survivors' benefits. The wife, husband, widow, or widower could get benefits without regard to the generally applicable 1-year duration-of-marriage requirement if in the month preceding the marriage the wife, husband, widow, or widower was actually or potentially entitled to a widow's, widower's, parent's, or (if over age 18) child's annuity under the Railroad Retirement Act. Also, a woman worker's husband or widower who was entitled to one of the specified railroad retirement annuities prior to the marriage to a person insured under social security could get benefits without regard to the generally applicable requirement for husband's or widower's benefits that the wife be currently insured—that is, have had a specified amount of recent covered work—and that she must have provided at least one-half of her husband's support.

Under present law, an exception to the 1-year duration-of-marriage requirement is made for a spouse of an insured worker if the spouse was, in the month preceding the marriage, actually or potentially entitled to social security benefits as a widow, widower, parent, or disabled adult child. Similarly, the Railroad Retirement Act provides an exception to the 1-year duration-of-marriage requirement for a wife's or husband's annuity in the case of a person who before marriage was eligible for a railroad retirement annuity as a widow, widower, parent, or disabled adult child, and for a widow's annuity in the case of a person who had, before marriage, qualified for a widow's

annuity under the railroad retirement program. The Railroad Retirement Act also makes an exception to the 1-year duration-of-marriage requirement for payment of widow's and widower's annuities in the case of a spouse who had, before marriage, actual or potential entitlement to benefits as a widow, widower, parent, or disabled adult child under social security. No similar exception is made under the Social Security Act for a spouse who, in the month preceding his or her marriage, had actual or potential entitlement to an annuity under the Railroad Retirement Act.

The duration-of-marriage requirements under the Social Security Act are intended to provide a safeguard against the payment of benefits where a marriage was undertaken mainly to secure benefits. Such a safeguard is not necessary when a person is or could be eligible for an annuity under the Railroad Retirement Act at the time of the marriage. The change the committee recommends will prevent people protected under the railroad retirement program from being left without social insurance protection because of marriage to a worker insured under the social security program.

12. COVERAGE EXTENSIONS AND MODIFICATIONS

The committee's bill would extend social security coverage to self-employment income from the practice of medicine, and to the wages of interns, cover tips as self-employment income, facilitate coverage of additional State and local government employees, provide additional coverage for employees of certain nonprofit organizations, extend coverage to temporary employees of the District of Columbia, increase the amount of gross income which farmers may use under the optional method of computing farm self-employment income for social security purposes, and permit exemption from the social security self-employment tax for persons who follow certain teachings of a religious sect of which they are members.

(a) Coverage of self-employed physicians and interns

Self-employed doctors of medicine are the only group of significant size whose self-employment income is excluded from coverage under social security. The committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible. There are no technical or administrative barriers to the coverage of self-employed doctors of medicine.

Moreover, more than half of the physicians in private practice have obtained some social security credits through work other than their self-employment as physicians, or through their military service.

The committee's bill would cover the self-employment income of the approximately 170,000 self-employed doctors of medicine on the same basis as the self-employment income of other professional groups. The committee amended the provision in the House bill so as to make social security coverage for self-employed doctors of medicine effective for taxable years ending on or after December 31, 1965. Under the House bill, coverage could be effective for taxable years ending after December 31, 1965. This change would make it possible for most self-employed physicians to obtain social security protection 1 year earlier than under the House bill—for calendar year 1965.

Coverage would also be extended to services performed by medical and dental interns. They would be covered on the same basis as other employees working for the same employers, beginning on January 1, 1966.

(*b*) *Computation of self-employment income from agriculture*

Under present law, persons with net earnings from farm self-employment have the following option in reporting for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $1,800, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $1,800 and net earnings are less than $1,200, either net earnings or $1,200 (two-thirds of $1,800) may be reported; and (*c*) if the annual gross income is more than $1,800 and net earnings are $1,200 or more, actual net earnings must be reported.

The bill approved by the committee would retain the present option in the reporting of farm self-employment income but would raise the level of income which may be reported under the gross income option by increasing the $1,800 figure to $2,400 and the $1,200 figure to $1,600.

Thus, persons with agricultural self-employment would be permitted to use the following option in reporting their earnings from agricultural self-employment for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $2,400, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $2,400 and actual net earnings are less than $1,600, either actual net earnings or $1,600 may be reported; and (*c*) if gross earnings are more than $2,400 and net earnings are more than $1,600, the actual net earnings must be reported. This change would be effective for taxable years beginning after December 31, 1965.

(*c*) *Coverage of tips*

The committee recognizes that more than a million employees now covered under the social security program have an important part of their income from work excluded from coverage because it is received in the form of tips, and that as a consequence such employees do not have adequate protection under social security. This situation should be corrected. However, the committee is not convinced that the provision in the House bill providing for the coverage of cash tips as wages is a workable provision.

Tips are an extremely unique type of income; and the committee believes that the most practical way to cover them is to treat them as self-employment income.

Tips received by employees which are accounted for to the employer by the employee are covered under present law as wages. There would be no change in the treatment of tips in this situation.

(*d*) *Coverage provisions applying to employees of States and localities*

(*1*) *Addition of Alaska to the States which may provide coverage through division of retirement systems*

Under a provision of the Social Security Act which is designed to facilitate the extension of social security coverage to members of State

and local government retirement systems, 18 specified States (and all interstate instrumentalities) are permitted to divide a State or local government retirement system into two parts for purposes of social security coverage, one part consisting of the positions of members who desire coverage, and the other consisting of the positions of members who do not desire coverage. Services performed by employees in the part consisting of the positions of members who desire coverage may then be covered under social security, and once those services are covered, the services of all persons who in the future become members of the retirement system must also be covered. The 18 States which are now permitted to extend coverage under this provision are California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin. The committee's bill would add Alaska to this group of States. The provision in the House bill which would also add Kentucky to this group of States has been deleted from the bill because the committee felt that it was not clear that the State of Kentucky desired this provision.

(2) Facilitating coverage under the provision for division of State and local government retirement systems

The bill would provide a further opportunity for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision permitting specified States to cover only those members of a retirement system who desire coverage. Under the present provision, the specified States may, during the 2-year period after coverage of a group is approved, cover additional employees who request coverage. (However, employees hired after coverage of the group is originally approved are covered on a compulsory basis.) The bill would reopen, or hold open, through December 31, 1966, the opportunity for election of coverage by those employees who had not elected coverage before the expiration of the 2-year period following approval of the coverage of their group.

The committee recognizes that employees who initially failed to elect coverage under the divided retirement system provision were provided two subsequent opportunities for election of coverage under amendments made to the Social Security Act in 1958 and 1961. Although in general it is important that the time limits for electing coverage be maintained and that it be known they will be maintained, this situation involves special circumstances which seem to your committee to justify providing one additional opportunity. The committee believes, however, that in the future there should be no further reopening of the opportunity for electing coverage under the divided retirement system provision beyond that which would be provided under this bill. We urge that those now contemplating participation in the program take timely action to exercise their choice.

The social security coverage of employees obtaining coverage as a result of the further opportunity provided by the proposed amendment would be required to begin on the same date as was provided when their group was originally covered.

(3) Coverage for certain additional hospital employees in California

The bill would modify a provision of the Social Security Amendments of 1960 which made coverage under the social security program available to certain hospital employees in the State of California who had performed services at some time during the period from January 1, 1957, through December 31, 1959, with respect to which contributions had been erroneously paid to the Internal Revenue Service prior to July 1, 1960. The 1960 legislation provided for crediting the remuneration which had been erroneously reported during the 1957–59 period, and for covering the services performed after 1959 by the individuals for whom the erroneous reportings had been made. The committee's bill would make it possible for the State to provide coverage, beginning with January 1, 1962, for the services of hospital employees employed in the positions in question after 1959, and to secure the crediting of remuneration erroneously reported for them for periods prior to 1962 if contributions with respect to such remuneration have been paid before the enactment of the bill. The State would have 6 months after the month of enactment in which to provide such coverage.

The individuals who would be affected by the committee's bill could not be covered under the 1960 legislation, since they were not in the group for which erroneous reports had been filed during the 1957 through 1959 period. And, like the employees to whom the 1960 legislation applied, they cannot be covered under the generally applicable provisions of the Social Security Act providing coverage for employees of States and localities.

Generally speaking, the Social Security Act does not permit States to bring under social security coverage persons whom the States have removed from coverage under a State and local retirement system. The positions of the employees in question were removed from coverage under the California State employees retirement system effective July 1, 1957, without awareness that this section established a bar to future social security coverage. This misunderstanding led to the erroneous reports, and created the need for the 1960 amendment.

The employees to whom the bill is directed have the same need for coverage as those to whom the 1960 legislation applied, and are barred from coverage under the general provisions of law in the same way as were the employees covered by the 1960 legislation. Your committee believes that they should be given the same opportunity to obtain protection under the social security program as was given in 1960 to hospital employees in a similar situation.

(4) Retirement systems in the State of Maine

The bill would reopen until July 1, 1970, a provision of law which permitted the State of Maine to treat teaching and nonteaching employees who are actually in the same retirement system as though they were under separate retirement systems for social security coverage purposes. The original provision, enacted as part of the Social Security Amendments of 1958, expired on June 30, 1960. The Social Security Amendments of 1960 reopened the provision until July 1, 1961. Legislation enacted in 1964 (Public Law 88–350) reopened the provision until July 1, 1965.

(5) Exclusion from coverage of certain students in Iowa and North Dakota

Under existing law, when a State extends coverage under its agreement with the Secretary of Health, Education, and Welfare to any group of employees, the State has the option of excluding from coverage certain types of employment, including those services performed by a student which would not be covered if the student worked for a nongovernmental employer. A State which originally excludes services it has the option of excluding—such as types of student services—may at any later date choose to cover them, but a State which has once covered such services may not later choose to exclude them. The committee has added a provision to the bill authorizing the State of Iowa and the State of North Dakota to modify their coverage agreements to exclude from social security coverage certain services performed by students, including service which the State has covered under its agreement. These States would be permitted to modify their agreements to exclude from social security coverage service performed in any calendar quarter in the employ of a school, college, or university by a student if the remuneration for such service is less than $50. Such a modification would specify the effective date of the exclusion, but it could not be earlier than the enactment date of the bill.

(e) Tax exemption for members of a religious group opposed to insurance

The committee's bill would permit exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. The exemption could be granted with respect to taxable years beginning after December 31, 1950.

The sect (or division thereof) must be one that has been in existence at all times since December 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. To qualify as grounds for the tax exemption, the objections of the individual and the sect (or division thereof) to insurance must include objections to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person. An individual's exemption (and the waiver of social security benefits) would be terminated if, and as of the time, the conditions under which the exemption was granted are no longer met, and the individual could not again be granted an exemption.

The committee believes that provisions for coverage under social security on an individual voluntary basis are undesirable, and we have been reluctant to recommend an amendment which would permit an individual to elect exemption from social security coverage. Present law provides no exemption by reason of an individual's religious beliefs. The voluntary coverage provisions for ministers are applicable only to ministerial services; a minister who does other work is covered on the same basis as any other person. We believe that an exemption from social security taxes with respect to work that is generally covered would be justifiable only in cases where it is amply clear that an individual cannot accept the benefits of insurance, including social security benefits, without renouncing basic tenets of his religion. The exemption we are recommending is designed to be granted in only such cases. The proposed exemption would be limited to the self-employment tax under social security since those persons for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment.

We believe that the proposed exemption must be on the basis of individual choice. To exclude all members of a religious group from social security coverage would not take account of the variances in individual beliefs within any religious group, and would deny social security protection to those individuals who want it. Among the Old Order Amish, for example, there have been some indications of a change in attitude toward social security, particularly among the younger people; some members of the Old Order Amish who have become eligible for social security benefits have claimed the benefits.

The committee believes that the recommended provision would provide relief for those individuals who sincerely believe that payment of social security taxes is irreconcilable with their religious convictions. We strongly recommend against any broadening of the proposed amendment since any such broadening could well lead to widespread individual voluntary coverage under social security, which would undermine the soundness of the social security program.

(f) Additional retroactive coverage of nonprofit organizations, and validation of coverage of certain employees of such organizations

Under present law the employees of a nonprofit organization may be covered under social security only if the employing organization files a certificate waiving its exemption from social security coverage.

The committee has learned that in some cases organizations have been reporting their employees for social security purposes without ever having filed the required waiver certificate. Such reports may be submitted for some time before the organization learns that they are erroenous. In such cases, employees who have been counting on having social security protection on the basis of their employment with such organization may in fact not have that protection.

The committee's bill would permit a nonprofit organization to elect social security coverage to be effective for a period of up to 5 years (rather than 1 year, as under present law) before the calendar quarter in which the waiver certificate electing social security is filed. In addition, nonprofit organizations which had filed a waiver certificate in or prior to the year in which the bill is enacted would be given until

the end of the year following enactment to amend their certificate to make social security coverage effective for a period of up to 5 years before the calendar quarter in which the amendment to the waiver certificate is filed.

The committee's bill adds a provision to the House bill which would give those employees to whom the additional retroactive coverage is applicable (as a result of the nonprofit organization amending its original waiver certificate) an individual choice of such additional coverage.

Thus, by making its waiver certificate sufficiently retroactive, a nonprofit organization that had been erroneously reporting earnings for its employees without having filed a certificate to elect coverage could ordinarily provide complete and continuous social security coverage for the erroneously reported employees. That is, a nonprofit organization which learns of its erroneous reporting could file a certificate electing coverage and make it sufficiently retroactive to cover the period for which employee earnings already reported would otherwise be stricken from the record because the statute of limitations had not run when the erroneous reporting had been discovered. The effect of the social security statute of limitations is that in most cases correction of an employee's social security earnings record may be made only if the error is discovered within 3 years, 3 months, and 15 days following the end of the year in which the wages were erroneously paid. The committee's bill would, then, resolve on a permanent basis troublesome problems which have arisen under the nonprofit coverage provisions.

The committee's bill also amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive credit for erroneously reported wages. The amendment applies to employees who are no longer in the employ of an organization when the waiver certificate is filed. These persons cannot be covered under the general provisions for retroactive coverage, as retroactive coverage is available only to persons still in the employ of an organization when the waiver certificate is filed. The amendment would permit such employees to have validated the reports of wages which had erroneously been made for them by the organization during the period of retroactive coverage. These persons have the same need for social security protection as those who are still employed by the organization when it files its waiver certificate.

Also, a provision is added to the House bill which would permit the validation of certain erroneously reported wages paid to employees of nonprofit organizations which have filed valid waiver certificates, but which nevertheless failed to provide effective social security coverage for some employees.

If a waiver certificate is filed by a nonprofit organization, then all current employees who sign a list at that time, those who sign a supplemental list in the 2-year period during which the certificate may be amended to cover additional employees, and all employees who are employed after the filing of the certificate, are covered for social security purposes. Some nonprofit organizations have erroneously reported for social security purposes some individuals employed when the certificate was filed who did not sign the required list of employees who want such coverage. The 1960 Social Security Amendments per-

mitted such employees to validate their erroneous reportings through June 30, 1960, and to secure future coverage beginning with the quarter following the quarter in which they request validation. Thus, if an employee validated his erroneous earnings in June 1963, for example, he secured coverage through June 30, 1960, and beginning on July 1, 1963. Thus, there would be under present law a gap in coverage from July 1, 1960, through June 30, 1963. The committee's bill adds a provision to the House bill which would permit such employees in this situation to remove the gap in their social security coverage.

(*g*) *Coverage of certain employees of the District of Columbia*

Under the present provisions of the Social Security Act, all service performed in the employ of the District of Columbia is excluded from social security coverage. Most District employees are covered under the Federal civil service retirement system or one of the two District retirement systems. Substitute teachers, however, are not covered under any government retirement system. Under the committee's bill, the District of Columbia could provide social security coverage for them. In addition, the bill would make it possible for the District of Columbia to cover under social security temporary or intermittent employees who are now covered under the civil service retirement system but, because of the temporary nature of their employment, do not obtain protection under that system. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

(*h*) *Validation of coverage of certain ministers*

Under present law, persons who have been in the ministry for at least 2 years after 1954 could obtain social security coverage of their earnings in the ministry by filing, before April 16, 1965, certificates waiving their exemption from social security taxes. The requirement that a waiver certificate must be filed within a specified period of time by a minister who desires social security coverage has been widely publicized on various occasions in the past in connection with legislation extending the time for filing such certificates. Some ministers have nevertheless reported their ministerial earnings for social security purposes and paid the social security contributions for several years without filing the required waiver certificate, and in some instances the lack of a waiver certificate has not been discovered until the death or retirement of the minister. In such instances, part or all of the earnings reported by the minister may not be creditable for social security purposes. The committee has been advised of cases in which the surviving widow and children of a deceased minister have suffered loss of social security protection because the deceased minister had failed to file the required waiver certificate, although he had reported his ministerial earnings for social security purposes and had paid the social security contributions. It believes that social security protection based on erroneously reported earnings should be provided for such survivors and for ministers who filed timely waiver certificates but who had previously reported earnings which cannot be credited under present law.

The committee's bill would permit the survivors of a minister who died before April 16, 1965, and who had filed social security tax returns without having filed a waiver, to file a waiver on the deceased

minister's behalf. A waiver filed by such survivors before April 16, 1967, would establish social security credit for the ministerial earnings reported by the deceased minister for taxable years after 1954.

In addition, the bill would permit ministers who filed waiver certificates before April 16, 1965, which were not effective for all years after 1954 for which they reported ministerial earnings for social security purposes to obtain social security credit for such earnings by filing a supplemental waiver certificate before April 16, 1967.

The committee's bill requires that all social security taxes which become due as a result of actions taken pursuant to this provision must be paid, or if previously refunded, repaid, before April 16, 1967. Benefits which become payable as a result of this provision would be payable beginning for the month after enactment of this bill.

13. MISCELLANEOUS

(*a*) *Extension of period for filing proof of support and application for lump-sum death payment*

The law provides that the proof of support required for husband's, widower's, and parent's insurance benefits, and applications for lump-sum death payments, must be filed within a 2-year period specified in the law. An extension of an additional 2 years is allowed where there was good cause for failure to file within the initial 2-year period. Many instances have arisen where there has been failure to file the required documents within the time allowed. A number of private bills have been proposed, and some enacted, to except specific individuals from this requirement in the law.

Believing that it is more desirable to provide for these situations by a provision of general law, the committee has included an amendment under which, if it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for failure to file within the initial 2-year period, an applicant would be allowed to file proof of support or an application for a lump-sum death payment at any time.

(*b*) *Automatic recomputation of benefits*

Under the bill provision is made for automatic annual recomputation of benefits to take account of earnings that a beneficiary may have after he comes on the rolls and that would increase his benefit amount. Under present law, benefit recomputations to take account of additional earnings generally are available only on application, and can be made only if the worker had covered earnings of more than $1,200 in a calendar year after he became entitled to benefits.

Experience has shown that a large number of people who are eligible for benefit recomputations to take account of additional earnings, and who will profit from such recomputations, fail to apply for them. Automatic recomputation would assure the beneficiary that he will get credit for any earnings that would increase his benefit amount. The committee has been advised that with the improved electronic equipment that is now used to compute benefit amounts, it is both feasible and administratively advantageous to handle these recomputations on an automatic basis.

An additional effect of the change would be to assure that no one would be disadvantaged by applying for benefits at age 65 instead of

waiting until a somewhat later age. Under present law, in some few cases a worker who delays the filing of his application gets a larger benefit than he would have gotten if he had applied at age 65. In certain situations, therefore, people do not know whether to apply for benefits or to defer filing. Sometimes they do apply and it turns out to have been disadvantageous. Under the provisions in the bill it will be possible to assure every claimant that he cannot lose by applying at age 65.

(c) *Reimbursement of the trust funds for the cost of military service credits*

Military service was not covered under the social security program on a contributory basis until 1957. However, special benefits were provided for the survivors of World War II veterans who died within 3 years after discharge, and noncontributory wage credits were provided under the program for active military service from September 16, 1940, through December 1956. The old-age and survivors insurance trust fund has been reimbursed for the cost of the benefits paid through August 1950, in the amount of about $15 million. However, although present law provides that the costs incurred through June 30, 1956, were to have been paid into the trust funds over the 10 fiscal years ending June 30, 1969, and that the costs incurred by the payment of such benefits after June 1956 were to have been appropriated annually, no such payments have been made.

The committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

(d) *Extension of life of application and determination of disability*

(1) *Life of applications*

Under present law, the prospective life of an application for monthly insurance benefits is limited to 3 months from the date of filing, except in the case of an application for disability benefits where the application must be filed within 3 months of the beginning of the waiting period. In effect, an applicant who does not meet the requirements for entitlement on the date of application has 3 months in which to meet them before his application expires.

A problem arises under present law when an application is disallowed and much later, during some stage of the appeals process and before a final decision on the application has been made by the Secretary, it is determined that the applicant first became eligible—for example, met the disability requirements or attained retirement age—after the period for which his application is effective has expired. The need for filing a new application may be discovered so late (an application may be effective retroactively for no more than 12 months) that no entitlement can be established for the first months of eligibility. If the claimant has died without filing a new application, no entitlement for any months can be established and a loss of all benefits is incurred.

The committee believes that the limitations in present law on the prospective life of an application for monthly insurance benefits or

for a determination of disability results in unnecessary inequities. As a result, the committee has included an amendment under which such an application would be valid if the applicant satisfies all the requirements for entitlement at any time before the Secretary makes a final decision on the application.

(*e*) *Overpayments and underpayments*

(*1*) *Recovery of overpayments*

The committee concurs with the recommendation of the General Accounting Office, made in a report to the Congress dated July 25, 1961, that the Secretary of Health, Education, and Welfare should have the authority to recover overpayments of social security benefits to a living person by withholding benefits of other people getting benefits on the same earnings record. (This authority is already provided in present law where the overpaid person is deceased.) Under the bill the Secretary would have authority, in any case where there had been an overpayment of either health insurance benefits or cash benefits, to recover the overpayment by withholding the cash social security benefits of the overpaid person or of other people who are getting benefits on the same earnings record, whether or not the overpaid person is alive.

(*2*) *Waiver of recovery*

Under present law, a beneficiary who is liable for repayment of an overpayment made to another person is denied the opportunity for waiver of recovery of the overpaid amount if the overpaid person was at fault, even though he himself is without fault and otherwise meets all the conditions prescribed in the law for having recovery waived. Under the bill, any beneficiary who is liable for repayment of an overpayment, whether the overpayment was made to him or to another person, would be able to qualify for waiver of recovery of the overpaid amount if he is without fault and if he meets the other conditions prescribed in the law.

(*3*) *Settlement of underpayments*

The present law provides that where "an error has been made" resulting in an underpayment to a beneficiary who has subsequently died, an adjustment is to be made by increasing the subsequent benefits of others getting benefits on the same earnings record as the deceased. The law does not contain any provision for the disposition of underpayments in death cases where there are no subsequent benefits payable. The committee believes that specific statutory authority should be provided to the Secretary to settle all claims for underpayments. This authority would be provided under the bill.

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

Benefits payable to a husband and wife living in the same household are usually paid in a single check issued to the two people jointly. When one payee of such a combined check dies, present procedures require that the check issued for the month of death be returned to the Treasury Department for cancellation, and that another check be issued to the surviving beneficiary as payment of the benefit to which the surviving beneficiary is entitled for that month. The delay involved in this procedure frequently results in hardship for the survivor. This hardship could be avoided if the surviving beneficiary

were authorized to cash the combined check on the condition that any resulting overpayment would be recovered. Since the Social Security Act does not contain any authority for making overpayments—and the combined check for the month of death would represent an overpayment because the surviving spouse is entitled only to his portion of the check—legislative authority is needed for making such temporary overpayments.

The bill would authorize the Secretary to make a temporary overpayment so as to permit the surviving spouse to cash the combined check for the month in which the other spouse died, with the provision that the overpayment resulting from cashing the combined check would be recovered.

(g) *Determination of attorney's fees in court proceedings*

It has come to the attention of the committee that attorneys have upon occasion charged what appear to be inordinately large fees for representing claimants in Federal district court actions arising under the social security program. Usually, these large fees result from a contingent-fee arrangement under which the attorney is entitled to a percentage (frequently one-third to one-half) of the accrued benefits. Since litigation necessarily involves a considerable lapse of time, in many cases large amounts of accrued benefits, and consequently large legal fees, are payable if the claimant wins his case.

The committee bill would provide that whenever a court renders a judgment favorable to a claimant, it would have express authority to allow as part of its judgment a reasonable fee, not in excess of 25 percent of accrued benefits, for services rendered in connection with the claim; no other fee would be payable. Any violation would be made subject to the same penalties as are provided in the law for charging more than the maximum fee prescribed in regulations for services rendered in connection with proceedings before the Secretary—up to $500, or a year's imprisonment, or both. In order to assure the payment of the fee allowed by the court, the Secretary would be permitted to certify the amount of the fee to the attorney out of the amount of the accrued benefits.

14. FINANCING PROVISIONS

Consistent with the well-established policy of maintaining the program on a financially sound basis, the bill makes full provision for meeting the cost of the improvements it would make in the old-age, survivors, and disability insurance program. Additional income would result from increasing the earnings base to $6,600 in 1966 and from the extensions of coverage provided under the bill. In addition, the committee is recommending a revised contribution rate schedule.

(a) *Increase in the contribution and benefit base*

As amended by the committee, the bill would raise from $4,800 to $6,600, beginning with 1966, the limitation on the amount of annual earnings that is used in determining benefits and that is subject to tax for the support of the program. This increase in the contribution and benefit base will make it possible to provide, for workers at and above average earnings levels, benefits that are more reasonably related to their actual earnings, and, by taxing a larger proportion of

the Nation's growing payrolls, will improve the financial base of the program.

The additional earnings that are taxed and credited for social security purposes make possible the payment of higher benefits and at the same time result in a reduction in the overall cost of the social security program as a percent of taxable payrolls.

The $6,600 contribution and benefit base effective in 1966—rather than increasing the base to $6,600 in two steps, to $5,600 in 1966 and to $6,600 in 1971, as provided for in the bill as passed by the House—not only will bring the benefits paid under the program into line with current earnings levels more quickly, but also will make possible lower contribution rates in 1966, 1967, and 1968 for old-age, survivors, and disability insurance, and lower contribution rates in 1966 for hospital insurance, than would otherwise be needed.

(*b*) *Changes in the contributions rates*

The schedule of contribution rates included in the bill will produce sufficient income to finance the social security program and at the same time will avoid large increases in the trust funds in the next few years. Under the schedule of rates the committee recommends, as under the revised schedule provided for in the bill as passed by the House, the tax rates for old-age, survivors, and disability insurance scheduled for the period 1966 through 1972 would be somewhat lower than those scheduled under present law. While the schedule in the bill as passed by the House would have lowered the rates scheduled to go into effect in 1966 from 4.125 percent each for employees and their employers to 4 percent each, the schedule recommended by the committee would lower the rates scheduled to go into effect in 1966 to 3.85 percent each for employees and their employers. After 1973 the contribution rate for employees and employers would be about three-tenths of 1 percent higher than scheduled under present law. Also, old-age, survivors, and disability insurance contributions for the self-employed person would be held at 5.8 percent of self-employment income through 1968 by the committee bill rather than increasing to 6.2 percent in 1966 and 6.9 percent in 1968 under present law. After 1973 the contribution rate for the self-employed under the committee bill would be only one-tenth of 1 percent higher than scheduled under present law.

The present and proposed contribution rates for old-age, survivors, and disability insurance are as follows:

Year	Contribution rates (in percent)					
	Employer and employee, each			Self-employed		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1965	3.625	3.625	3.625	5.4	5.4	5.4
1966–67	4.125	4.0	3.85	6.2	6.0	5.8
1968	4.625	4.0	3.85	6.9	6.0	5.8
1969–72	4.625	4.4	4.45	6.9	6.6	6.7
1973 and after	4.625	4.8	4.9	6.9	7.0	7.0

15. ADVISORY COUNCIL ON SOCIAL SECURITY

The bill would repeal the present provisions for the appointment of future Advisory Councils on Social Security Financing and provide instead for the appointment of Advisory Councils of broader scope and of somewhat different representation.

The Councils provided for under present law are, in general, required to report only on the financing of the program. The Council that was appointed in 1963 and made its report on January 1 of this year was the only Council required to present its findings and recommendations with respect to all aspects of the program. That Council urged that "every 5 years or so Advisory Councils be formed to review the substantive provisions of the program as well as its financing." The committee agrees with this recommendation, and under the bill the scope of future Advisory Councils would be broadened so that all future Councils would report on all aspects of the program (including the new hospital insurance and supplementary medical insurance programs established under the bill) and on their impact on the public assistance programs.

Present law requires that the Councils be composed of 12 members representing employers and employees in equal numbers and self-employed persons and the public. The bill provides that the Council members shall, to the extent possible, represent employer and employee organizations in equal numbers and self-employed persons and the public.

The Councils would submit their reports to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees. Under the time schedule for the appointment of Advisory Councils now in the law, Councils are to be appointed in 1966 and every fifth year thereafter and report on January 1 of the second year after the year of appointment. This schedule was designed so that a Council would report 1 year before each tax increase, and every fifth year after the final increase. In 1961 the final tax increase, previously scheduled for 1969, was rescheduled for 1968. As a result, the Council to be appointed in 1966 is required to make its report on the day on which the final rate increase now in the law is scheduled to go into effect. Under the bill, the next Advisory Council would be appointed in 1968 and make its report not later than January 1, 1970. Subsequent Councils would be appointed so as to report in 1975 and every fifth year thereafter.

16. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The old-age, survivors, and disability insurance system, as modified by the committee-approved bill, has an estimated cost for benefit payments and administrative expenses that is very closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by the committee-approved bill has been shown to be not quite self-supporting under the intermediate cost estimate. Nevertheless, there is close to an exact balance, especially considering that a range of variation is

necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by the committee-approved bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows a favorable actuarial balance of 0.02 percent of taxable payroll under the provisions that would be in effect after enactment of the committee-approved bill, because the contribution rate allocated to this fund is slightly more than the cost of the disability benefits, based on the intermediate cost estimate. Considering the variability of cost estimates for disability benefits, this small actuarial surplus is not significant. The disability insurance program, as it would be modified by the committee-approved bill, is actuarially sound.

(*b*) *Financing policy*

(*1*) *Contribution rate schedule for old-age, survivors, and disability insurance in committee-approved bill*

The contribution schedule for old-age, survivors, and disability insurance contained in the committee-approved bill is lower than that under present law by 0.55 percent in the combined employer-employee rate in 1966–67, is lower by 1.55 percent in 1968, is lower by 0.35 percent in 1969–72, and is higher by 0.45 percent in 1973 and thereafter. The maximum earnings base to which these tax rates in the committee-approved bill are applied is $6,600 for 1966 and thereafter, as contrasted with $5,600 per year for 1966–70 and $6,600 for 1971 and after under the House-approved bill and $4,800 under present law. These tax schedules are as follows:

[Percent]

Calendar year	Employee rate (same for employer)			Self-employed rate		
	Present law	House-approved bill	Committee-approved bill	Present law	House-approved bill	Committee-approved bill
1965	3.625	3.625	3.625	5.4	5.4	5.4
1966–67	4.125	4.00	3.85	6.2	6.0	5.8
1968	4.625	4.00	3.85	6.9	6.0	5.8
1969–72	4.625	4.40	4.45	6.9	6.6	6.7
1973 and after	4.625	4.80	4.90	6.9	7.0	7.0

The allocation rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the committee-approved bill and the House-approved bill, as compared with present law, are as follows:

[Percent]

Calendar year	Old-age and survivors insurance			Disability insurance		
	Present law	House-approved bill	Committee-approved bill	Present law	House-approved bill	Committee-approved bill
1965	6.75	6.75	6.75	0.50	0.50	0.50
1966–67	7.75	7.25	7.00	.50	.75	.70
1968	8.75	7.25	7.00	.50	.75	.70
1969–72	8.75	8.05	8.20	.50	.75	.70
1973 and after	8.75	8.85	9.10	.50	.75	.70

(2) Self-supporting nature of system

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has always very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is not always the case for well-administered private pension plans, which may not have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group. These additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long run, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

The committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, the view has been held that for the old-age and survivors insurance portion of the

program, if such actuarial insufficiency has been no greater than 0.25 percent of payroll, when measured over perpetuity, it is at the point where it is within the limits of permissible variation. The corresponding point for the disability insurance portion of the system is about 0.05 percent of payroll (lower because of the relatively smaller financial magnitude of this program). Based on the recommendation of the 1963–64 Advisory Council on Social Security Financing (see app. V of the 25th Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, H. Doc. No. 100, 89th Cong.), the cost estimates are now being made on a 75-year basis, rather than on a perpetuity basis. On this approach, the margin of variation from exact balance should be smaller—no more than 0.10 percent of taxable payroll for the combined old-age, survivors, and disability insurance program.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in the committee-approved bill are in conformity with these financing principles.

(c) *Basic assumptions for cost estimates*

(1) *General basis for long-range cost estimates*

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1975 and thereafter) are presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. Both the low- and high-cost estimates are based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1963. The use of 1963 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1963, the aggregate amount of earnings taxable under the program was $226 billion. Of course, when new workers enter the labor force in years after 1963, the total taxable earnings increase simply because of multiplying the larger number of covered workers by the 1963 average earnings rates. In addition to the presentation of the cost estimates on a range basis, intermediate estimates developed directly from the low- and high-cost estimates (by averaging their components) are shown so as to indicate the basis for the financing provisions.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is

that the number of births in the 1930's was very low as compared with subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2010, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(2) *Measurement of costs in relation to taxable payroll*

In general, the costs are shown as percentages of covered payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to a greater extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of $300 per month. Under the bill such an individual would have a primary insurance amount of $112.40. If his earnings rate should increase by 50 percent (to $450), his primary insurance amount would be $146. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 30 percent. Or to put it another way, when his earnings rate was $300 per month, his primary insurance amount represented 37.5 percent of his earnings, whereas, when his earnings increased to $450 per month, his primary insurance amount relative to his earnings decreased to 32.4 percent.

(3) *General basis for short-range cost estimates*

The short-range cost estimates (shown for the individual years 1965–72) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future, paralleling that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have been prepared on the basis of the same assumptions and methodology as those contained in the 25th Annual Report of the Board of Trustees (H. Doc. No. 100, 89th Cong.).

(4) *Level-cost concept*

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the old-age and survivors insurance trust fund would result, and in consequence there would be sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost

concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) *Future earnings assumptions*

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings rates of covered workers by age and sex will continue over the next 75 years at the levels experienced in 1963. This, however, does not mean that covered payrolls are assumed to be the same each year; rather, they are assumed to rise steadily as the population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income. This is an important reason for considering costs relative to payroll rather than in dollars.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following the high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). The possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace with rising earnings trends as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since, under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) Interrelationship with railroad retirement system

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service (and also for all survivor cases).

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that over the long range the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

(7) Reimbursement for costs of military service wage credits

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the committee-approved bill. These reimbursements would be made on the basis of constant annual amounts (although adjusted in accordance with actual experience) over the next 50 years, rather than on the basis of the actual disbursements each year, as under present law.

(d) Actuarial balance of program in past years

(1) Status after enactment of 1952 act

The actuarial balance under the 1952 act [1] was estimated, at the time of enactment, to be virtually the same as in the estimates made at the time the 1950 act was enacted, as shown in table G. This was the case, because the estimates for the 1952 act took into consideration the rise in earnings levels in the 3 years preceding the enactment of that act. This factor virtually offset the increased cost due to the benefit liberalizations made. New cost estimates made 2 years after the enactment of the 1952 act indicated that the level-cost (i.e., the average long-range cost, based on discounting at interest, relative to taxable payroll) of the benefit disbursements and administrative expenses was somewhat more than 0.5 percent of payroll higher than the level-equivalent of the scheduled taxes (including allowance for interest on the existing trust fund).

[1] The term "1952 act" (and similar terms) is used to designate the system as it existed after the enactment of the amendments of that year.

TABLE G.—*Actuarial balance of old-age, survivors, and disability insurance program under various acts for various estimates, intermediate-cost basis*

[Percent]

Legislation	Date of estimate	Level-equivalent [1]		
		Benefit costs [2]	Contributions	Actuarial balance [3]
		Old-age, survivors, and disability insurance [4]		
1935 act	1935	5.36	5.36	0.00
1939 act	1939	5.22	5.30	+0.08
1939 act (as amended in the 1940's) [5]	1950	4.45	3.98	−.47
1950 act	1950	6.20	6.10	−.10
1950 act	1952	5.49	5.90	+.41
1952 act	1952	6.00	5.90	−.10
1952 act	1954	6.62	6.05	−.57
1954 act	1954	7.50	7.12	−.38
1954 act	1956	7.45	7.29	−.16
1956 act	1956	7.85	7.72	−.13
1956 act	1958	8.25	7.83	−.42
1958 act	1958	8.76	8.52	−.24
1958 act	1960	8.73	8.68	−.05
1960 act	1960	8.98	8.68	−.30
1961 act	1961	9.35	9.05	−.30
1961 act	1963	9.33	9.02	−.31
1961 act (perpetuity basis)	1964	9.36	9.12	−.24
1961 act (75-year basis)	1964	9.09	9.10	+.01
1965 bill (House)	1965	9.44	9.36	−.08
1965 bill (Senate committee)	1965	9.61	9.51	−.10
		Old-age and survivors insurance [4]		
1956 act	1956	7.43	7.23	−0.20
1956 act	1958	7.90	7.33	−.57
1958 act	1958	8.27	8.02	−.25
1958 act	1960	8.38	8.18	−.20
1960 act	1960	8.42	8.18	−.24
1961 act	1961	8.79	8.55	−.24
1961 act	1963	8.69	8.52	−.17
1961 act (perpetuity basis)	1964	8.72	8.62	−.10
1961 act (75-year basis)	1964	8.46	8.60	+.14
1965 bill (House)	1965	8.73	8.61	−.12
1965 bill (Senate committee)	1965	8.93	8.81	−.12
		Disability insurance [4]		
1956 act	1956	0.42	0.49	+0.07
1956 act	1958	.35	.50	+.15
1958 act	1958	.49	.50	+.01
1958 act	1960	.35	.50	+.15
1960 act	1960	.56	.50	−.06
1961 act	1961	.56	.50	−.06
1961 act	1963	.64	.50	−.14
1961 act (perpetuity basis)	1964	.64	.50	−.14
1961 act (75-year basis)	1964	.63	.50	−.13
1965 bill (House)	1965	.71	.75	+.04
1965 bill (Senate committee)	1965	.68	.70	+.02

[1] Expressed as a percentage of effective taxable payroll, including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate. Estimates prepared before 1964 are on a perpetuity basis, while those prepared after 1964 are on a 75-year basis. The estimates prepared in 1964 are on both bases (see text).

[2] Including adjustments (*a*) to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate, (*b*) for the interest earnings on the existing trust fund, (*c*) for administrative expense costs, and (*d*) for the net cost of the financial interchange provisions with the railroad retirement system.

[3] A negative figure indicates the extent of lack of actuarial balance. A positive figure indicates more than sufficient financing, according to the particular estimate.

[4] The disability insurance program was inaugurated in the 1956 act so that all figures for previous legislation are for the old-age and survivors insurance program only.

[5] The major changes being in the revision of the contribution schedule; as of the beginning of 1950, the ultimate combined employer-employee rate scheduled was only 4 percent.

NOTE.—The figures for the 1950 act and for the 1952 act according to the 1952 estimates have been revised as compared with those presented previously, so as to place them on a comparable basis with the later figures.

(2) Status after enactment of 1954 act

Under the 1954 act, the increase in the contribution schedule met all the additional cost of the benefit changes and at the same time reduced substantially the actuarial insufficiency that the then-current estimates had indicated in regard to the financing of the 1952 act.

(3) Status after enactment of 1956 act

The estimates for the 1954 act were revised in 1956 to take into account the rise in the earnings level that had occurred since 1951–52, the period that had been used for the earnings assumptions for the estimates made in 1954. Taking this factor into account reduced the lack of actuarial balance under the 1954 act to the point where, for all practical purposes, it was nonexistent. The benefit changes made by the 1956 amendments were fully financed by the increased contribution income provided. Accordingly, the actuarial balance of the system was unaffected.

Following the enactment of the 1956 legislation, new cost estimates were made to take into account the developing experience; also, certain modified assumptions were made as to anticipated future trends. In 1956–57, there were very considerable numbers of retirements from among the groups newly covered by the 1954 and 1956 amendments, so that benefit expenditures ran considerably higher than had previously been estimated. Moreover, the analyzed experience for the recent years of operation indicated that retirement rates had risen or, in other words, that the average retirement age had dropped significantly. This may have been due, in large part, to the liberalizations of the retirement test that had been made in recent years—so that aged persons were better able to effectuate a smoother transition from full employment to full retirement. The cost estimates made in early 1958 indicated that the program was out of actuarial balance by somewhat more than 0.4 percent of payroll.

(4) Status after enactment of 1958 act

The 1958 amendments recognized this situation and provided additional financing for the program—both to reduce the lack of actuarial balance and also to finance certain benefit liberalizations made. In fact, one of the stated purposes of the legislation was "to improve the actuarial status of the trust funds." This was accomplished by introducing an immediate increase (in 1959) in the combined employer-employee contribution rate, amounting to 0.5 percent, and by advancing the subsequently scheduled increases so that they would occur at 3-year intervals (beginning in 1960) instead of at 5-year intervals.

The revised cost estimates made in 1958 for the disability insurance program contained certain modified assumptions that recognized the emerging experience under the new program. As a result, the moderate actuarial surplus originally estimated was increased somewhat, and most of this was used in the 1958 amendments to finance certain benefit liberalizations, such as inclusion of supplemental benefits for certain dependents and modification of the insured status requirements.

(5) Status after enactment of 1960 act

At the beginning of 1960, the cost estimates for the old-age, survivors, and disability insurance system were reexamined and were modified in certain respects. The earnings assumption had previously

been based on the 1956 level, and this was changed to reflect the 1959 level. Also, data first became available on the detailed operations of the disability provisions for 1956, which was the first full year of operation that did not involve picking up "backlog" cases. It was found that the number of persons who meet the insured status conditions to be eligible for these benefits had been significantly overestimated. It was also found that the disability incidence experience for eligible women was considerably lower than had been originally estimated, although the experience for men was very close to the intermediate estimate. Accordingly, revised assumptions were made in regard to the disability insurance portion of the program. As a result, the changes made by the 1960 amendments could, according to the revised estimates, be made without modifying the financing provisions.

(6) Status after enactment of 1961 act

The changes made by the 1961 amendments involved an increased cost that was fully met by the changes in the financing provisions (namely, an increase in the combined employer-employee contribution rate of one-fourth of 1 percent, a corresponding change in the rate for the self-employed, and an advance in the year when the ultimate rates would be effective—from 1969 to 1968). As a result, the actuarial balance of the program remained unchanged.

Subsequent to 1961, the cost estimates were further reexamined in the light of developing experience. The earnings assumption was changed to reflect the 1963 level, and the interest rate assumption used was modified upward to reflect recent experience. At the same time, the retirement rate assumptions were increased somewhat to reflect the experience in respect to this factor. The further developing disability experience indicated that costs for this portion of the program were significantly higher than previously estimated (because benefits are not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance of the disability insurance program was shown to be in an unsatisfactory position, and this has been recognized by the Board of Trustees, who recommended that the allocation to this trust fund should be increased (while, at the same time, correspondingly decreasing the allocation to the old-age and survivors insurance trust fund, which under present law is estimated to be in satisfactory actuarial balance even after such a reallocation).

(e) Intermediate-cost estimates

(1) Purposes of intermediate-cost estimates

The long-range intermediate-cost estimates are developed from the low- and high-cost estimates by averaging them (using the dollar estimates and developing therefrom the corresponding estimates relative to payroll). The intermediate-cost estimate does not represent the most probable estimate, since it is impossible to develop any such figures. Rather, it has been set down as a convenient and readily available single set of figures to use for comparative purposes.

The Congress, in enacting the 1950 act and subsequent legislation, was of the belief that the old-age, survivors, and disability insurance program should be on a completely self-supporting basis and actuarially sound. Therefore, a single estimate is necessary in the develop-

ment of a tax schedule intended to make the system self-supporting. Any specific schedule will necessarily be somewhat different from what will actually be required to obtain exact balance between contributions and benefits. This procedure, however, does make the intention specific, even though in actual practice future changes in the tax schedule might be necessary. Likewise, exact balance cannot be obtained from a specific set of integral or rounded tax rates increasing in orderly intervals, but rather this principle of self-support should be aimed at as closely as possible.

(*2*) *Interest rate used in cost estimates*

The interest rate used for computing the level-costs for the committee-approved bill is 3½ percent for the intermediate-cost estimate This is somewhat above the average yield of the investments of the trust funds at the end of 1964 (about 3.13 percent), but is below the rate currently being obtained for new investments (about 4⅛ percent).

(*3*) *Actuarial balance of OASDI system*

Table G has shown that according to the latest cost estimates made for the 1961 act there is an almost exact actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.13 percent of taxable payroll for the disability insurance portion, and a favorable balance of 0.14 percent of taxable payroll for the old-age and survivors insurance portion.

Under the committee-approved bill, the benefit changes proposed would be approximately financed by the increases in the contribution rates and the earnings base.

Table H traces through the change in the actuarial balance of the system from its situation under the 1961 act, according to the latest estimate, to that under the committee-approved bill, by type of major changes involved, while table I gives similar data for the committee-approved bill as compared with the House-approved bill.

TABLE H.—*Changes in actuarial balance of old-age, survivors, and disability insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, present laws and committee-approved bill, based on 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	+0.14	−0.13	+0.01
Earnings base increase from $4,800 to $6,600	+.51	+.04	+.55
Revised contribution schedule	+.18	+.20	+.38
Extensions of coverage	+.03		+.03
7-percent benefit increase [1]	−.59	−.05	−.64
Earnings test liberalization	−.27	−.01	−.28
Child's benefits to age 22 if in school	−.10	−.02	−.12
Reduced widow's benefits at age 60 [2]			
Disability definition revision [3]		−.01	−.01
Transitional insured status for certain persons aged 72 and over	−.01		−.01
Broader definition of "child" [4]	−.01		−.01
Total effect of changes in bill	−.26	+.15	−.11
Actuarial balance under bill	−.12	+.02	−.10

[1] Includes also the effect of the minimum increase of $4 in the primary insurance amount. The 7-percent increase does not apply beyond the first $400 of average monthly wage; the same benefit factor underlying present law for average monthly wages in excess of $110 applies for that portion of the average monthly wage above $400.

[2] Includes also the cost of the provisions for paying benefits to certain divorced women.

[3] Includes also the cost of the provision for permitting the payment of disability benefits after the individual has first become entitled to some other benefit and the savings arising from the offset provision when workmen's compensation benefits are also payable.

[4] Includes also the cost of the provision for paying child's benefits with respect to children disabled at ages 18 to 21.

TABLE I.—*Changes in actuarial balance of old-age, survivors, and disability insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, House-approved bill and committee-approved bill, based on 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance under House-approved bill	−0.12	+0.04	−0.08
Earnings base increase to $6,600 effective in 1966	+.03		+.03
Revised contribution schedule (see (b)(1))	+.16		+.16
Revised allocation to DI trust fund (see (b)(1))	+.05	−.05	
Earnings test liberalization	−.23	−.01	−.24
Changes in disability definition [1]		+.04	+.04
Broader definition of "child" [2]	−.01		−.01
Total effect of changes in committee-approved bill	.00	−.02	−.02
Actuarial balance under committee-approved bill	−.12	+.02	−.10

[1] Includes also the savings arising from the offset provision when workmen's compensation benefits are also payable.

[2] Includes also the cost of the provision for paying child's benefits with respect to children disabled at ages 18 to 21.

The changes made by the committee-approved bill would reasonably maintain the actuarial position of the old-age, survivors, and disability insurance system. The estimated favorable actuarial balance of 0.01 percent of taxable payroll for the present system would be slightly changed—to a lack of balance of 0.10 percent, which is the established limit within which the system is considered substantially in actuarial balance.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high-level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(4) *Level-costs of benefits, by type*

The level-cost of the old-age and survivors insurance benefits (without considering administrative expenses and the effect of interest earnings on the existing trust fund) under the 1961 act, according to the latest intermediate-cost estimate, is about 8.51 percent of taxable payroll on the 75-year basis and the corresponding figure for the program as it would be modified by the committee-approved bill is 8.94 percent. The corresponding figures for the disability benefits are 0.62 percent for the 1961 act and 0.67 percent for the committee-approved bill.

Table J presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of the committee-approved bill, separately for each of the various types of benefits.

TABLE J.—*Estimated level-cost of benefit payments, administrative expenses, and interest earnings on existing trust fund under the old-age, survivors, and disability insurance system, after enactment of committee-approved bill, as percentage of taxable payroll,*[1] *by type of benefit, intermediate-cost estimate at 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.37	0.54
Wife's benefits	.51	.04
Widow's benefits	1.11	(2)
Parent's benefits	.01	(2)
Child's benefits	.67	.09
Mother's benefits	.16	(2)
Lump-sum death payments	.11	(2)
Total benefits	8.94	.67
Administrative expenses	.13	.03
Railroad retirement financial interchange	.04	.00
Interest on existing trust fund [3]	−.18	−.02
Net total level-cost	8.93	.68

[1] Including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate.
[2] This type of benefit is not payable under this program.
[3] This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

The level contribution rate equivalent to the graded schedule in the law may be computed in the same manner as level-costs of benefits.

These are shown in table G, as are also figures for the net actuarial balances.

(5) OASI income and outgo in near future

Under the committee-approved bill, old-age and survivors insurance benefit disbursements for the calendar year 1965 will be increased by about $1.3 billion, since the effective dates for the benefit changes are January 1965 for the 7-percent benefit increase and child's benefits to age 22 while in school, and the second month after the month of enactment for most of the other changes. There will, of course, be no additional income during 1965, since the contribution rate increases and the change in the earnings base are effective on January 1, 1966.

In calendar year 1965, benefit disbursements under the old-age and survivors insurance system as modified by the committee-approved bill will total about $17.0 billion. At the same time, contribution income for old-age and survivors insurance in 1965 will amount to about $16.0 billion under the committee-approved bill, the same as under present law. Thus, benefit outgo under the committee-approved bill will exceed contribution income by about $1.0 billion, whereas under present law, contribution income is estimated to exceed benefit outgo by about $370 million. The size of the old-age and survivors insurance trust fund under the committee-approved bill will, on the basis of this estimate, decrease by about $1.2 billion in 1965 (interest receipts are somewhat less than the outgo for administrative expenses and for transfers to the railroad retirement account); under present law, it is estimated that this trust fund would increase by about $250 million as between the beginning and the end of 1965.

In 1966, benefit disbursements under the old-age and survivors insurance system as it would be modified by the committee-approved bill will be about $18.8 billion, or an increase of about $2.4 billion over present law. Contribution income for old-age and survivors insurance under the committee-approved bill for 1966 will be $18.8 billion, or about $0.4 billion more than under present law. Accordingly, in 1966, contribution income and benefit outgo will be about the same under the committee-approved bill. There will be an excess of contributions over benefit outgo of about $600 million in 1967 and about $500 million in 1968.

Under the system as modified by the committee-approved bill, according to this estimate, the old-age and survivors insurance trust fund will be about $270 million lower at the end of 1966 than at the beginning of the year. It will then increase by about $240 million in 1967 and $220 million in 1968, reaching $18.1 billion at the end of 1968. In the next 2 years, as a result of the scheduled increase in the contribution rate in 1969, the trust fund will increase by about $3 to $4 billion each year.

(6) DI income and outgo in near future

Under the disability insurance system, as it would be affected by the committee-approved bill in calendar year 1965, benefit disbursements will total about $1,600 million (or about $130 million more than under present law), and there will be an excess of benefit disbursements over contribution income of about $410 million. In 1966 and the years immediately following, contribution income will be well in

excess of benefit outgo (as a result of the increased allocation to this trust fund, and the increased taxable earnings base, as provided by the committee-approved bill).

The disability insurance trust fund is estimated to decrease by about $470 million in 1965 under the committee-approved bill, as compared with a corresponding decrease of about $330 million under present law; the greater decrease results primarily from the retroactive 7-percent benefit increase. The trust fund at the end of 1966 will be about the same size as at the beginning of the year, but after 1966 it will increase in every year.

(7) Increases in benefit disbursements in 1966, by cause

The total benefit disbursements of the old-age, survivors, and disability insurance system would be increased by about $2.6 billion in 1966 as a result of the changes that the committee-approved bill would make. Of this amount, about $1.5 billion results from the 7-percent benefit increase, $195 million from the benefit payments to children aged 18–21 who are in full-time school attendance, $165 million from the benefit payments to widows aged 60–61, $140 million from the liberalization of the insured-status provisions for certain persons aged 72 and over, $40 million from the liberalization of the definition of disability, $590 million from the liberalization of the earnings test (the corresponding figure for this change for subsequent years will be about 25 percent higher), $10 million for the broader definition of "child," and $10 million for paying benefits to children disabled at ages 18–21.

(8) Long-range operations of OASI trust fund

Table K gives the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by the committee-approved bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty—if for no reason other than the relative difficulty in predicting future birth trends—but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity.

TABLE K.—*Progress of old-age and survivors insurance trust fund under system as modified by committee-approved bill, intermediate-cost estimate at 3.50 percent interest* [3]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [3]	Balance in fund at end of year [1]
	Actual data					
1951	$3,367	$1,885	$81	.....	$417	$15,540
1952	3,819	2,194	88	.....	365	17,442
1953	3,945	3,006	88	.....	414	18,707
1954	5,163	3,670	92	−$21	447	20,576
1955	5,713	4,968	119	−7	454	21,663
1956	6,172	5,715	132	−5	526	22,519
1957	6,825	7,347	[4] 162	−2	556	22,393
1958	7,566	8,327	[4] 194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
	Estimated data (short-range estimate)					
1965	$16,014	$16,987	$351	$436	$571	$17,936
1966	18,834	18,824	377	445	540	17,664
1967	20,450	19,874	363	532	556	17,901
1968	21,264	20,771	369	483	583	18,125
1969	25,164	21,666	377	499	660	21,407
1970	26,676	22,568	385	487	817	25,460
1971	27,522	23,483	393	457	991	29,640
1972	28,414	24,406	401	455	1,171	33,963
	Estimated data (long-range estimate)					
1975	$29,144	$25,144	$390	$319	$1,192	$39,485
1980	31,456	29,179	431	135	1,873	59,260
1990	36,002	37,145	510	−21	2,632	80,723
2000	41,759	41,571	559	−77	3,144	96,999
2025	51,816	63,179	769	−107	3,766	111,683

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

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

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

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

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

In every year after 1965 for the next 20 years, contribution income under the system as it would be modified by the committee-approved bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial

interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the long-range cost estimate (with a level-earnings assumption), reaching $39 billion in 1975, $59 billion in 1980, and over $95 billion at the end of this century. In the very far distant future, namely, in about the year 2015, the trust fund is estimated to reach a maximum of about $150 billion.

(9) Long-range operations of DI trust fund

The disability insurance trust fund, under the program as it would be changed by the committee-approved bill, grows slowly but steadily after 1966, according to the intermediate long-range cost estimate, as shown by table L. In 1975, it is shown as being $3.7 billion, while in 1990, the corresponding figure is $8.1 billion. There is a small excess of contribution income over benefit disbursements for every year after 1965.

TABLE L.—*Progress of disability insurance trust fund under system as modified by committee-approved bill, intermediate-cost estimate at 3.50-percent interest* [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year
	Actual data					
1957	$702	$57	[3] $3	----------	$7	$649
1958	966	249	[3] 12	----------	25	1,379
1959	891	457	50	−$22	40	1,825
1960	1,010	568	36	−5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,647
	Estimated data (short-range estimate)					
1965	$1,187	$1,599	$85	$24	$51	$1,577
1966	1,820	1,730	102	25	47	1,587
1967	2,049	1,824	108	28	50	1,726
1968	2,133	1,898	112	21	55	1,883
1969	2,208	1,959	115	24	61	2,054
1970	2,283	2,014	119	26	67	2,245
1971	2,357	2,066	122	29	75	2,460
1972	2,434	2,114	125	31	84	2,708
	Estimated data (long-range estimate)					
1975	$2,249	$2,053	$100	−$3	$117	$3,704
1980	2,427	2,244	103	−11	156	4,873
1990	2,779	2,516	104	−13	264	8,139
2000	3,223	2,962	116	−13	452	13,747
2025	4,000	4,047	151	−13	897	26,850

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

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

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

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

(f) Cost estimates on range basis

(1) Long-range operations of trust funds

Table M shows the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by the committee-approved bill for low- and high-cost estimates, while table N gives corresponding figures for the disability insurance trust fund.

Under the low-cost estimate, the old-age and survivors insurance trust fund builds up quite rapidly and in the year 2000 is shown as being about $270 billion and is then growing at a rate of about $16 billion a year. Likewise, the disability insurance trust fund grows steadily under the low-cost estimate, reaching about $9 billion in 1980 and $34 billion in the year 2000, at which time its annual rate of growth is about $2 billion. For both trust funds, under these estimates, benefit disbursements do not exceed contribution income in any year after 1965 for the foreseeable future.

TABLE M.—*Estimated progress of old-age and survivors insurance trust fund under system as modified by committee-approved bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$29,759	$24,656	$361	$299	$1,603	$49,407
1980	32,443	28,331	398	106	2,738	80,513
1990	38,394	35,366	469	−51	5,264	150,470
2000	45,776	38,962	515	−112	9,417	267,643
	High-cost estimate					
1975	$28,528	$25,633	$418	$339	$872	$29,985
1980	30,470	30,027	464	156	1,171	39,110
1990	33,611	38,924	550	9	443	15,018
2000	37,742	44,180	603	−42	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1993.

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

TABLE N.—*Estimated progress of disability insurance trust fund under system as modified by committee-approved bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$2,296	$1,914	$91	−$6	$197	$5,782
1980	2,503	2,080	92	−15	301	8,699
1990	2,963	2,323	91	−18	628	17,881
2000	3,532	2,773	100	−18	1,195	33,684
	High-cost estimate					
1975	$2,202	$2,192	$109	0	$46	$1,546
1980	2,352	2,408	113	−$7	29	1,044
1990	2,594	2,709	116	−8	[3]	[3]
2000	2,913	3,150	133	−8	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1985.

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

On the other hand, under the high-cost estimate the old-age and survivors insurance trust fund builds up to a maximum of about $40 billion in about 15 years, but decreases thereafter until it is exhausted somewhat before the year 2000. Under this estimate, benefit disbursements from the old-age and survivors insurance trust fund are lower than contribution income during all years after 1969 and before 1981.

As to the disability insurance trust fund, under the high-cost estimate, in the early years of operation the contribution income is about the same as the benefit outgo. Accordingly, the disability insurance trust fund, as shown by this estimate, will be about $1.5 billion during the first few years after 1965 and will then slowly decrease until it is exhausted in 1985.

The foregoing results are consistent and reasonable, since the system on an intermediate-cost-estimate basis is intended to be approximately self-supporting, as indicated previously. Accordingly, a low-cost estimate should show that the system is more than self-supporting, whereas a high-cost estimate should show that a deficiency would arise later on. In actual practice, under the philosophy in the 1950 and subsequent acts, as set forth in the committee reports therefor, the tax schedule would be adjusted in future years so that none of the developments of the trust funds shown in tables M and N would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions were not changed, the contribution rates would probably be adjusted downward—or perhaps would not be increased in future years according to schedule. On the other hand, if the experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. At any rate, the high-cost estimate does indicate that, under the tax schedule adopted,

there will be ample funds to meet benefit disbursements for several decades, even under relatively high-cost experience.

(2) Benefit costs in future years relative to taxable payroll

Table O shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by the committee-approved bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs for the low-, high-, and intermediate-cost estimates (as was previously shown in tables G and J for the intermediate-cost estimate).

TABLE O.—*Estimated cost of benefits of old-age, survivors, and disability insurance system as percent of taxable payroll,*[1] *under system as modified by committee-approved bill*

[In percent]

Calendar year	Low-cost estimate	High-cost estimate	Intermediate cost estimate [2]
	Old-age and survivors insurance benefits		
1975	7.56	8.20	7.87
1980	7.96	8.99	8.46
1990	8.40	10.56	9.41
2000	7.76	10.67	9.07
2025	8.92	14.21	11.10
2040	10.12	15.27	12.15
Level-cost [3]	7.83	10.34	8.93
	Disability insurance benefits		
1975	0.58	0.70	0.64
1980	.58	.72	.65
1990	.55	.73	.63
2000	.55	.76	.64
2025	.63	.83	.71
2040	.67	.87	.75
Level-cost [3]	.61	.79	.68

[1] Taking into account the lower contribution rate for the self-employed, as compared with the combined employer-employee rate.

[2] Based on the averages of the dollar contributions and dollar costs under the low-cost and high-cost estimates.

[3] Level contribution rate, at an interest rate of 3.25 percent for high-cost, 3.50 percent for intermediate-cost, and 3.75 percent for low-cost, for benefits after 1964, taking into account interest on the trust fund on Dec. 31, 1964, future administrative expenses, the railroad retirement financial interchange provisions, the reimbursement of military-wage-credits cost, and the lower contribution rates payable by the self-employed.

E. PUBLIC ASSISTANCE AMENDMENTS

1. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES

The committee's bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first $35 of the average assistance payment to thirty-one thirty-sevenths of

the first $37 of the average assistance payment. The ceiling is raised on the average payments from $70 a month to $75 a month. The provisions in the formula under titles I and XVI adding $15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of Aid to Families with Dependent Children (A.F.D.C.) program, the formula change made in the committee's bill would be from fourteen-seventeenths of the first $17 of the average payment per recipient to five-sixths of the first $18 of the average assistance payment. The ceiling is raised from $30 a month to $32 a month. Under the committee's bill, there would be an increase in Federal payments averaging about $2.50 a month for the needy recipients in the adult assistance categories and an increase of about $1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had traditionally been accepted as a responsibility of the States.

There have been many encouraging developments, in the meantime, in the care and treatment of the mentally ill and tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

For these reasons in reporting the social security bill (H.R. 11865) last year, the committee added a provision, similar to the provision in this year's bill, which removes the distinction hitherto maintained in the public assistance titles of the Social Security Act—between the aged who are ill with a diagnosis of psychosis or tuberculosis and the aged with other diagnosed illnesses.

Under the provisions of the committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled (title XVI) who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, and are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of psychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the eligibility of patients for public assistance with Federal participation in the payments made.

The House bill incorporated special standards of care for mental and tuberculous patients. The Department of Health, Education, and Welfare has informed the committee that the number of aged tuberculous patients is so small that, with present methods of treatment, special safeguards are not necessary for this group. A committee amendment would accordingly leave the safeguards fully applicable to the mentally ill but would eliminate the special requirements for treatment of aged persons with tuberculosis who are in specialized institutions. A description of the safeguards follows:

For those States that wish to take advantage of Federal participation in payments to the mentally ill who are in institutions for mental disease, the bill requires a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. The committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus the committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for the aged person who had been placed under an alternate plan of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under the committee bill, the agreement must include these arrangements.

A second safeguard, under the committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the mental hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review of his medical and other needs. The committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under the committee bill, the State plan would also need to assure that the medical care needed by the patient

will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

The committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 Public Welfare Amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under the committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

The committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State. Social services may be needed for members of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, the committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

The committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus the committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. The committee expects that this determination will be made without imposing burdensome fiscal methods on the States.

The committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by the committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, the committee's bill makes the approvability of a State's plan for assistance for aged individuals in mental hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program—including utilization of community mental health centers, nursing homes, and other alternative forms of care.

The committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. The committee bill provides that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by States and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

3. AID TO FAMILIES WITH DEPENDENT CHILDREN IN SCHOOL

Under existing law States, at their option, may continue payments to needy children up to age 21 in the aid to families with dependent children program, providing they are "regularly attending a high school in pursuance of a course of study leading to a high school diploma or its equivalent, or regularly attending a course of vocational or technical training designed to fit him for gainful employment." The committee added an amendment extending this provision so as to include needy children under 21 who are regularly "attending a school, college, or university." Federal sharing for this purpose would thus be available to States who implement such a program for payments to children regularly attending a college, or university, as well as those attending high school or a vocational school, thus bringing this provision more nearly in line with the provision of the bill relating to the continuation of a child's benefit under the OASDI system. The objective of the provision in both programs is to assure, as far as possible, that children will not be prevented from going to school or college because they are deprived of parental support.

4. PROTECTIVE PAYMENTS

The House bill reflected a concern about the problems of our aged citizens who have marginal capacity to handle their own affairs. The committee believes that similar problems may exist as to some needy blind under title X and some of the needy disabled under title XIV and has extended the protective payments feature to these programs. States may now, with Federal participation, use guardians as payees for public assistance payments, or under section 1111 of the Social Security Act enacted in 1958, may use a special legal representative as the payee. The committee has been advised that these arrangements still do not offer enough flexibility to meet all the needs that arise and thus, the bill contains additional provisions.

Under the committee's bill, States with Federal financial participation may make a protective payment to a third party, someone with an interest or concern for the individual recipient. This provision is similar to the protective payment provision included in the AFDC program as one part of the 1962 Public Welfare Amendments. It would be effective January 1, 1966, and would be applicable to recipients of money payments under title I or title XVI.

The committee is aware of the serious nature of a decision not to give a needy person the money which he would ordinarily receive directly, but instead to pay it in his behalf to a third party. The committee's bill, therefore, has several safeguards to protect the individual's rights. For Federal sharing to be claimed in such payments, the State plan, under the bill, would have to show that a determination will be made that such individual has, by reason of his physical or mental condition, such inability to manage his own money that making payments directly to him would not be in his best interest. Furthermore, States would be able to make payments with Federal sharing only when the payments meet all the need, as determined under the State plan, of the individual. This safeguard was included by the committee because some States do not meet need according to their own standards and thus it is possible that the difficulty ascribed to the individual in handling his money may be due to the inadequate assistance he is receiving.

The State plan would have to show, in addition, that the State is undertaking and continuing efforts to protect the welfare of the individual and to the extent possible, improve his capacity for self-care and to handle his money. To avoid the possibility of protective payment arrangements continuing beyond the period necessary, the bill provides, further, that the State agency will need to make periodic reviews to determine whether conditions justify the continuation of the arrangement and if they do not, for direct payments to be resumed, or if the conditions warrant, for the judicial appointment of a guardian or a legal representative as authorized by section 1111 of the Social Security Act. The bill also provides specifically that the State agency must offer to the individual affected, if he is dissatisfied, an opportunity for a fair hearing on the decision to make his payment to a third party.

5. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER PUBLIC ASSISTANCE PROGRAMS

(a) Old-age assistance

The committee's bill provides for a modest increase in the amount of earnings States may disregard in determining need under the program of OAA and for the aged receiving assistance under the combined program for the aged, blind, and disabled (title XVI). Currently, States may disregard no more than the first $10 a month, and one-half of the remainder within a total of $50 per month of earned income. The bill would raise those amounts to $20 a month and one-half of the remainder within a total of $80 per month of earned income, effective January 1, 1966.

The committee is convinced that it is sound for the aged to continue in employment as long as they can, and that those who work should have some incentive and special consideration. Currently 23

States have implemented the earlier legislation and are disregarding some earned income of the aged. This amendment will permit these States, and others that have not yet acted, to implement the legislation to increase the amounts disregarded.

(*b*) *Aid to families with dependent children*

Under existing law, any earnings of any member of the family in the aid to families with dependent children program are taken into account in determining eligibility for and the amount of the assistance payment. This means that if a child in such a family gets a job, the amount of the family payment is reduced by the amount of his earnings. To remove this disincentive for children to work, the committee added an amendment which would allow a State at its option, in determining need for needy families in this category, to disregard up to $50 per month of earned income of any three dependent children under the age of 18 in the same home.

(*c*) *Aid to the permanently and totally disabled*

The committee added an amendment to the bill making available, at the option of a State, the same exemption of earnings for permanently and totally disabled recipients that the bill includes for the aged, i.e. the first $20 per month plus one-half of the next $60. This should be an incentive to rehabilitation in those instances where it is feasible. The amendment would also permit States to exempt, for up to 36 months, any additional income or resources necessary to achieve a plan of self-support. The latter exemption would be made only under a State-approved plan and only during the period or periods that the individual was actually undergoing vocational rehabilitation.

(*d*) *OASDI benefit increase attributable to retroactive effective date*

Under title III of the bill, beneficiaries of the OASDI program will receive a 7-percent increase in their benefits retroactively effective to January 1, 1965. These benefits will be payable to beneficiaries in a lump-sum check in addition to the regular monthly check. There are currently thousands of such beneficiaries who are receiving supplementary assistance from various of the public assistance programs under the provisions of the Social Security Act. Moreover, certain children over 18 and in school will receive benefits from January 1, 1965. The committee believes that it would be appropriate for the State public assistance agencies to disregard these retroactive payments as one-time-only income, not significant in amount and not income which under various other longstanding provisions of the public assistance titles to the act must be taken into account by the State in determining the amount of assistance for the individual. The committee added clarifying language to assure that this section only takes care of cases where the payments for prior months are due to the provision in the bill making the OASDI benefit increase and the new children's benefits retroactive to January 1, 1965.

(*e*) *Economic Opportunity Act*

Section 701 of the Economic Opportunity Act of 1964 provides that certain amounts of income of an individual derived from titles I and II of that act may not be taken into account by State public assistance agencies in determining the need of such individual or any other indi-

vidual for public assistance under programs authorized by the Social Security Act. The purpose of this amendment was to provide an incentive for persons who are beneficiaries of programs under the Economic Opportunity Act to undertake training and employment by permitting public assistance payments to continue for them and their families, if they are otherwise eligible, and not be reduced by specified amounts of their income under such programs. The statute provides that States with a legislative impediment to putting this provision into effect shall have until July 1, 1965, to obtain the necessary legislative change. A problem has arisen in the instance of States which do not have a regular meeting of their legislature until 1966 to make the necessary changes to State law. Under this section of the bill, such States would have until the first month following the month of adjournment of a State's first regular legislative session adjourning after the date of enactment of the Economic Opportunity Act of 1964 to act.

(*f*) *Income exempt under another assistance program*

Existing law (sec. 1109) requires that when income is exempted in determing the need of a blind person under title X of the Social Security Act that the income which has been exempted for the blind individual shall not be taken into account in determining the need of another individual, such as a spouse or dependent, who is applying for assistance under one of the other public assistance titles. The House bill extends this principle to the new "Title XIX—Medical Assistance." The committee added an amendment which would make the principle applicable to all public assistance programs, since a number of earnings exemptions are now required or authorized under the various public assistance titles.

6. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

The committee bill contains new provisions effective January 1, 1966 for administrative and judicial review of certain administrative determinations under titles I, IV, X, XIV, XVI, and XIX of the Social Security Act. These provisions are designed to assure that the States will not encounter undue delays in obtaining Federal determinations on acceptability of proposed State plan material under the public assistance programs, and that the States will be able to obtain judicial review of their plan proposals at an appropriate stage of the proceedings. These provisions are not intended to affect adversely the usual negotiation process between the Department of Health, Education, and Welfare and the States which, in nearly all instances, results in the development of a State plan or plan amendment that can be approved by the Secretary.

When a State submits a new plan under one of the public assistance titles, the Secretary shall make a determination within 90 days as to whether the proposal meets the applicable requirements for approval. This period may be extended by written agreement of the Secretary and the State. If the State is dissatisfied with the Secretary's determination, it may, within 60 days, petition for a reconsideration. The House bill provided that the Secretary shall then set a time and place for a hearing but no time limit was set as to when the notice of hearing was to be given. The committee bill would require that

notice of the time and place of the hearing be given within 30 days of the State's request for a hearing. Under the bill the hearing is to begin from 20 to 60 days after the date notice is furnished to the State, unless the Secretary and the State agree in writing upon another time. Within 60 days of the conclusion of the hearing, the Secretary shall affirm, modify, or reverse his original determinations. If the State is dissatisfied with this final determination it may, within 60 days, appeal to the U.S. court of appeals.

Under the House bill, in the judicial proceeding, the findings of fact by the Secretary shall be conclusive, unless substantially contrary to the weight of the evidence. The committee bill substitutes wording so that the findings shall be conclusive "if supported by substantial evidence", which terminology appears in virtually all of our grant-in-aid statutes, as well as the Administrative Procedure Act. If good cause is shown for taking further evidence, the court may remand the case to the Secretary for this purpose. The court may affirm the action of the Secretary or set it aside, in whole or in part. The court's judgment shall be subject to review by the Supreme Court of the United States upon certiorari or certification.

The foregoing procedures are also applicable, at the option of the State, upon submittal of any amendment of an approved State plan.

The bill does not amend sections 4, 404, 1004, 1404, 1604, or 1904 of the Social Security Act, which provide that the Secretary shall give reasonable notice and opportunity for hearing to a State prior to discontinuing payments under a previously approved State plan because of his finding that the plan has been so changed that it no longer complies with certain requirements or that in the administration of the plan there is a failure to comply substantially with certain requirements. However, the bill provides that upon any such final determination by the Secretary, the State may appeal to the U.S. court of appeals, in the same way as described above for appeals from a final determination of the Secretary in connection with submittal of a new plan.

The bill further provides that action pursuant to an initial determination of the Secretary, as therein described, shall not be stayed pending reconsideration. If the Secretary subsequently determines that his initial determination was incorrect, he shall pay forthwith in a lump sum any amounts, not otherwise already paid, which are payable to the State in accordance with the corrected determination of the Secretary on the basis of the expenditures made by the State.

In addition to questions concerning State plan proposals, or which involve discontinuance of Federal payments under part or all of a State plan, disagreements between a State and the Secretary may occur when the Secretary disallows specific State expenditures for Federal financial participation. Such disallowances usually take the form of audit exceptions. The bill provides that whenever the Secretary determines that there shall be a disallowance the State shall be entitled, on request, to an administrative reconsideration of the decision.

7. MAINTENANCE OF STATE EFFORT

Under various provisions of this bill, additional Federal funds will be available to States to improve the public assistance program. The committee has recognized the need for such program improve-

ment in medical care, in basic maintenance, as well as in other areas, and believes that the Federal funds designated for these purposes should be used by the States for these purposes and not as a substitute for State funds. For this reason, the bill incorporates a provision which assures that the additional Federal funds made available to States are used within the public assistance program. Additional Federal funds will, under these provisions, be granted to States only to the extent that existing State expenditures in the program are maintained. For a period beginning January 1, 1966, and ending June 30, 1969, a measurement of these expenditures will be made in the process of granting the Federal funds to the States. The committee believes that after June 30, 1969, the new funds will be so integrated into the programs of the States that further testing of this fact will not be needed.

Under the bill, expenditures from total and Federal funds for a particular quarter are compared with total and Federal expenditures in a "base period," either the corresponding quarter or an average of the quarters in the fiscal year ending June 30, 1964, or June 30, 1965. If this comparison shows that the increase in Federal funds as computed under the revised formula exceeds the increase in total expenditures, the increase in the Federal share must be reduced to the amount of the increase in total expenditures between the base period and the quarter in question. The purpose of this provision is to assure that whatever additional Federal funds are made available to the States under the revised formulas for computing the Federal share and under provisions for program expansion will be used for program improvements and that no part of any additional Federal funds will be used to replace non-Federal funds.

8. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

When the MAA program was enacted in 1960, the law prohibited Federal sharing in MAA payments made in behalf of an aged person receiving OAA in the month MAA services were received. This provision has proved to be a hardship in the planning of States for the necessary movement of ill aged persons to and from medical institutions such as nursing homes and hospitals. For the month of movement to or from such a medical facility, States are faced with a heavy expenditure of funds, only part of which, under current provisions of law, is subject to Federal sharing. A State which has made an OAA payment to a needy person to cover his expenses in his own home is unable to claim any Federal funds as MAA when the individual goes to a medical institution that month. The reverse situation arises when the individual leaves the medical institution in which services are received under MAA.

In order to meet this need, the bill would relax the prohibition on Federal sharing in OAA and MAA for the same month so as to permit such sharing effective July 1, 1965, for MAA services furnished in the month an individual enters or leaves a medical facility.

9. COSTS OF INCREASES IN THE PUBLIC ASSISTANCE MATCHING FORMULAS

The accompanying table shows by State and by assistance programs the additional amounts of money that will be available to States under

the changes in public assistance formulas made by title IV. These total almost $150 million for the first full year, or $75 million for the 6 months of the fiscal year ending June 30, 1966, that they would be effective. Like other increases in public assistance provided by the bill, the States would receive these amounts only to the extent that they made corresponding increases in their total expenditures.

Public assistance: Estimated annual increase in Federal funds under proposal to raise participation in assistance payments to specified levels [1]

[In thousands]

States and District of Columbia	Total all programs	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to the aged, blind, and disabled (title XVI)	Aid to families with dependent children
Total	$148,520	$50,953	$2,352	$10,194	$22,117	$62,904
Alabama	3,817	2,640	42	346	----------	789
Alaska	154	(2)	(2)	(2)	69	85
Arizona	933	319	38	68	----------	508
Arkansas	2,012	1,392	47	221	----------	352
California	22,919	11,495	523	2,008	----------	8,893
Colorado	2,731	[3] 1,735	11	253	----------	732
Connecticut	1,543	321	13	172	----------	1,037
Delaware	203	32	13	18	----------	140
District of Columbia	581	100	8	130	----------	343
Florida	3,354	(2)	(2)	(2)	2,167	1,187
Georgia	3,691	2,206	76	624	----------	785
Hawaii	344	(2)	(2)	(2)	97	247
Idaho	494	220	6	67	----------	201
Illinois	8,543	(2)	(2)	(2)	3,751	4,792
Indiana	1,260	557	76	45	----------	582
Iowa	2,172	1,286	54	50	----------	782
Kansas	1,829	(2)	(2)	(2)	1,201	628
Kentucky	2,620	(2)	(2)	(2)	1,682	938
Louisiana	4,992	3,186	134	452	----------	1,220
Maine	568	(2)	(2)	(2)	329	239
Maryland	1,791	(2)	(2)	(2)	519	1,272
Massachusetts	4,497	2,295	96	494	----------	1,612
Michigan	5,308	(2)	(2)	(2)	2,481	2,827
Minnesota	2,008	[3] 988	48	82	----------	890
Mississippi	2,874	1,782	71	415	----------	606
Missouri	4,288	2,489	164	351	----------	1,284
Montana	456	249	11	58	----------	138
Nebraska	968	553	29	108	----------	278
Nevada	199	107	7	[4]	----------	85
New Hampshire	315	196	12	25	----------	82
New Jersey	2,510	335	40	349	----------	1,786
New Mexico	950	(2)	(2)	(2)	331	619
New York	12,844	(2)	(2)	(2)	3,977	8,867
North Carolina	3,099	1,047	122	523	----------	1,407
North Dakota	476	(2)	(2)	(2)	330	146
Ohio	6,860	2,873	141	786	----------	3,060
Oklahoma	6,115	(2)	(2)	(2)	4,650	1,465
Oregon	1,036	269	18	187	----------	562
Pennsylvania	6,484	1,937	216	471	----------	3,860
Rhode Island	802	(2)	(2)	(2)	374	428
South Carolina	1,228	629	43	205	----------	351
South Dakota	404	174	3	26	----------	201
Tennessee	2,373	1,099	53	301	----------	920
Texas	6,899	5,504	116	221	----------	1,058
Utah	647	122	8	114	----------	403
Vermont	224	(2)	(2)	(2)	159	65
Virginia	1,058	322	28	161	----------	547
Washington	2,540	812	28	437	----------	1,263
West Virginia	1,978	352	20	148	----------	1,458
Wisconsin	2,375	1,266	35	252	----------	822
Wyoming	154	64	2	26	----------	62

[1] For OAA, AB, APTD, and AABD (title XVI) raise 29/35 of $35 to 31/37 of $37; and for AFDC, from 14/17 of $17 to 5/6 of $18; raise maximum average monthly payment from $70 to $75; and for AFDC, from $30 to $32. Assumes that States will continue to spend the same amount per recipient from State and local funds as in May 1964, and that the increase in Federal funds will be used to raise money payments to recipients.

[2] Combined under aid to the aged, blind, and disabled.

[3] Based on State's estimate of the number of recipients and average payment for September 1964, which shows transfers from OAA to MAA, not reflected in May data.

[4] No program for APTD.

F. Medical Expenses

In addition to providing for the health needs of our elderly citizens, the House bill made several changes in the provisions of the Internal Revenue Code relating to deduction of medical expenses. The principal amendments would have denied deductions for substantial amounts of expenses incurred by persons over age 65 for their medical care, and would have granted additional deductions to persons under age 65 by allowing a portion of health insurance premiums to be deducted outside the regular medical expense category. The committee deleted both of these provisions from the House bill.

The House bill also made certain other changes of a more technical nature. These changes, explained more fully below, have been retained by the committee's bill.

1. PROVISIONS OF THE HOUSE BILL APPROVED

Under the committee's bill, as under the House bill, the definition of medical care is revised to specifically limit the deductible portion of premiums paid on multipurpose health and accident policies to the actual cost of providing insurance protection against medical-care expenses, as defined in the Internal Revenue Code. The cost of insurance allocable to income continuation payments when illness or accident causes absence from work and the cost of insurance which provides indemnity in the case of the loss of limb, etc., is not to be deductible.

Under the House bill it was required that that portion of the multipurpose premium which is for medical care (and therefore deductible) be stated in the policy issued by the insurance company. A technical amendment approved by the committee insures that this information alternatively may be reported to the insured in a separate statement.

Both the committee's bill and the House bill qualify as a current medical expense certain premiums paid during the taxable year by a taxpayer under the age of 65 for insurance for the medical care expenses of the taxpayer, his spouse, and his dependents which will be incurred after the taxpayer attains the age of 65. However, these payments, to qualify as a current expense, must be made under a contract which provides for level premium payments over a specified minimum period. This provision, which applies only to insurance for medical care expenses, is designed to remove any impediment which might otherwise exist to the voluntary provision by a person under 65 of medical care protection for his post-65 years. This is not intended, however, to foreclose the allowance of any presently available deduction for other prepayments.

In addition, both bills assure that the amounts paid by individuals for the supplementary medical insurance provided by new title XVIII will be treated as a medical expense for purposes of the income tax deduction, and that the special maximum limitation presently available only with respect to disabled taxpayers (and their spouses) who are age 65 or over is to be extended to all disabled taxpayers regardless of their age. These provisions apply to medical care expenses incurred in taxable years beginning after December 31, 1966.

2. PROVISIONS OF THE HOUSE BILL DELETED

One provision of the House bill which the committee was unwilling to accept would have narrowed the deduction for medical care expenses of taxpayers (or dependent parents) age 65 or over to the amount of such expenses in excess of 3 percent of their adjusted gross income. Medicine and drug costs included in medical care expenses also would have been restricted to the amount in excess of 1 percent of adjusted gross income.

The committee is not willing to increase the income taxes of aged, ill, and infirm taxpayers who provide for their own medical protection. We point out that as recently as last year in the Revenue Act of 1964 Congress repealed the provision which limited their medicine and drug expense to the amount in excess of 1 percent of their adjusted gross income. The reports of both the House Ways and Means Committee and the Committee on Finance of the Senate explaining last year's amendment noted the simplification which elimination of the 1-percent limit would achieve and expressed our common belief that it was "undesirable to impose any minimum limitation with respect to the deductibility of medical expenses in the case of the aged."

By deleting from the House bill these features which imposed new limits on medical expense deductions of the aged, the committee restates its position of last year.

The other provision the committee was not willing to accept would have allowed all taxpayers to deduct one-half of the cost of medical-care insurance outside the regular medical expense category. This would have provided new tax relief for taxpayers under age 65. The committee was not prepared to treat a portion of medical expenses as if it were not a regular medical expense. In addition, the committee was concerned that the precedent set here might later be extended into other areas of tax law.

For these reasons, and because the Treasury Department strongly resisted this amendment, the committee has deleted it from the House bill.

G. Miscellaneous Provisions

1. OPTOMETRISTS

The committee has added a provision which will be effective as to all titles of the Social Security Act so that it will be clear that whenever payment is authorized for services which an optometrist is licensed to perform, the beneficiary shall have the freedom to obtain the services of either a physician skilled in diseases of the eye or an optometrist, whichever he may select. This should make it clear that when it comes to the expenditure of Federal funds, beneficiaries should be free to avail themselves of the services of optometrists if they so desire.

2. ADDITIONAL UNDER SECRETARY AND ASSISTANT SECRETARIES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

To carry out the greatly expanded activities of the Department of Health, Education, and Welfare, which are provided in this bill, the committee believes that it is prudent to authorize an additional Under Secretary and two new Assistant Secretaries. The Under Secretary

shall perform such duties as the Secretary of Health, Education, and Welfare may prescribe and shall serve as Secretary during the absence or disability of the Secretary and the Under Secretary now provided for in accordance with directives of the Secretary. The rate of compensation of such additional Under Secretary and Assistant Secretaries shall be the same as that applicable to the Under Secretary and Assistant Secretaries, respectively, whose positions are established by section 2 of the Reorganization Plan No. 1 of 1953.

3. NEED FOR ADDITIONAL SUPERGRADES

To meet the substantial increase and responsibility and to put the Social Security Administration on a basis more nearly comparable to other agencies the committee recommends a substantial increase in the number of supergrades. The committee is concerned over the fact that the Social Security Administration, which requires a staff of 36,000 people to conduct its operations, has only 15 supergrade positions—a ratio of 2,400 to 1. Many agencies in the Government with only a fraction of this number of employees have more supergrades. The allocation of higher level positions to the social security program has not kept pace with the rapid growth of the program. Enactment of this bill would result not only in further substantial increases in the number who are actually getting benefits but also in an enormous increase in the scope and variety of the benefits payable and in the administrative complexities involved in the operations of the program. It is particularly important therefore that there be allocation of supergrades to the Social Security Administration commensurate with its duties and responsibilities.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the "Social Security Amendments of 1965"—and a table of contents. The remainder of the bill is divided into four titles, and titles I and II into several parts, as follows:

Title I—Health Insurance for the Aged and Medical Assistance
- Part 1—Health Insurance Benefits for the Aged
- Part 2—Grants to States for Medical Assistance Programs

Title II—Other Amendments Relating to Health Care
- Part 1—Maternal and Child Health and Crippled Children's Services
- Part 2—Implementation of Mental Retardation Planning
- Part 3—Public Assistance Amendments Relating to Health Care
- Part 4—Miscellaneous Amendments Relating to Health Care

Title III—Social Security Amendments

Title IV—Public Assistance Amendments

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

Section 100 of the bill provides that title I of the bill may be cited as the "Health Insurance for the Aged Act."

PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

SECTION 101. ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Section 101 of the bill adds at the end of title II of the Social Security Act a new section 226, dealing with entitlement to hospital insurance benefits (i.e., entitlement to have payment of benefits made under part A of the new title XVIII of the Social Security Act (as added by section 102 of the bill)).

Section 226(a) provides that any individual who has attained the age of 65, and who is entitled to monthly old-age and survivors insurance benefits or is a "qualified railroad retirement beneficiary", is entitled to hospital insurance benefits under part A of the new title XVIII for each month (including, if applicable, any month of retroactive entitlement to monthly OASI benefits as provided in section 202(j)(1) of the Social Security Act and any month of retroactive entitlement to benefits as provided in section 21 of the Railroad Retirement Act of 1937) in which he meets such conditions, beginning with July 1966.

Paragraph (1) of section 226(b) provides that entitlement of an individual to hospital insurance benefits consists of entitlement to

have payment made on his behalf for inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services 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)). It also provides that no payment for posthospital extended care services may be made for services furnished before January 1967 and that payment for posthospital extended care services or posthospital home health services may be made only if the discharge from a hospital required to permit payment with respect to such services occurs after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later.

Paragraph (2) of section 226(b) provides that an individual entitled under section 226 is entitled to hospital insurance benefits for the month in which he dies.

Section 226(c) provides that 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 (as added by sec. 105 of the bill), and that an individual will cease to be a qualified railroad retirement beneficiary at the close of the month before the month which is certified by the Board as the month in which he ceased to meet the requirements of such section 21.

Section 226(d) contains a cross-reference to section 103 of the bill which provides entitlement to hospital insurance benefits for certain individuals not eligible for benefits under section 226.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

Section 102(a) of the bill amends the Social Security Act by adding after title XVII a new title XVIII providing health insurance for the aged and consisting of part A (hospital insurance for the aged), part B (supplementary medical insurance benefits for the aged), and part C (miscellaneous provisions).

TITLE XVIII—HEALTH INSURANCE FOR THE AGED

SECTION 1801. PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Section 1801 states that nothing in the new title XVIII is to be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine, the manner in which medical services are provided, the personnel policies of providers of health care, or the operation or administration of medical facilities and personnel.

SECTION 1802. FREE CHOICE BY PATIENT GUARANTEED

Section 1802 provides that any individual entitled to benefits under title XVIII may obtain health services from any institution, agency, or person which is qualified to participate under the title and which undertakes to provide the services to him.

SECTION 1803. OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

Section 1803 provides that nothing in title XVIII is to be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against health costs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

SECTION 1811. DESCRIPTION OF PROGRAM

Section 1811 describes the insurance program for which entitlement is established under section 226 of the Social Security Act as one which provides basic protection against the costs of hospital and related posthospital services for individuals age 65 or over who are entitled to retirement benefits under title II of the Social Security Act or under the railroad retirement system.

SECTION 1812. SCOPE OF BENEFITS

Section 1812(a) provides that the benefits provided to an individual under part A of the new title XVIII consist of entitlement to have payment made on his behalf for—

(1) inpatient hospital services (including such services in a psychiatric hospital or a tuberculosis hospital) for up to 120 days during any spell of illness;

(2) posthospital extended care services for up to 100 days during any spell of illness;

(3) posthospital home health services for up to 175 visits (during any 1-year period described in sec. 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and

(4) outpatient hospital diagnostic services.

Section 1812(b) provides that payment may not be made for inpatient hospital services (including inpatient psychiatric hospital services and inpatient tuberculosis hospital services) furnished to an individual in any spell of illness after such services have been furnished to him for 120 days during the spell; or for posthospital extended care services in any spell of illness after such care has been furnished to him for 100 days during the spell; or for inpatient psychiatric hospital services after such services have been furnished to him during his lifetime for a total of 210 days.

Section 1812(c) provides that if an individual is an inpatient of a psychiatric or a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under part A, the days on which he was an inpatient of such a hospital in the 120-day period immediately before such first day will be included in determining the 120-day limit on inpatient hospital services insofar as it applies to him.

Section 1812(d) provides that payment may be made under part A for posthospital home health services furnished an individual only during the 1-year period or periods described in section 1861(n) following his most recent hospital or extended care facility discharge which meets the requirements of such section. Only the first 175 visits occurring in the period or periods and after the beginning of one spell of illness and before the beginning of the next spell of illness can be paid

for. The number of visits to be charged in connection with the provision of covered home health items or services for this purpose is to be determined in accordance with regulations.

Section 1812(e) provides that inpatient hospital services, posthospital extended care services, and posthospital home health services will be taken into account for purposes of the limits on duration of coverage prescribed in the preceding subsections of section 1812 only if payment under part A is made or would be made with respect to such services if they had been furnished within such limits and if the request and certification requirements described in section 1814(a) had been met for such services.

Section 1812(f) contains a cross reference to the definitions of the terms used in part A which are found in section 1861.

SECTION 1813. DEDUCTIBLES

Paragraph (1) section 1813(a) provides that the amount payable for inpatient hospital services furnished during any spell of illness will be reduced by the inpatient hospital deductible (the amount of which is determined under section 1813(b)) or, if less, by the charges imposed for such services or the customary charges for such services, whichever is greater. The amount would be further reduced by a deduction equal to one-fourth of the inpatient hospital deductible for each day before the 121st day of inpatient hospital services after such services have been furnished for 60 days during a spell of illness.

Paragraph (2) of section 1813(a) provides that the amount payable with respect to outpatient hospital diagnostic services (furnished during a diagnostic study) shall be reduced by a deduction equal to the sum of one-half the amount of the inpatient hospital deductible and by 20 percent of the remainder of the amount payable. A "diagnostic study" is defined as outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (once he is entitled to benefits under section 226) on which outpatient hospital diagnostic services are furnished to him.

Paragraph (3) of section 1813(a) provides that the amount payable to any provider of services under part A shall be reduced by an amount equal to the cost of the first 3 pints of whole blood furnished to an individual during a spell of illness.

Paragraph (4) of section 1813(a) provides that the amount payable for posthospital extended care services furnished during any spell of illness will be reduced by a deduction equal to one-eighth of the inpatient hospital deductible for each day such services are furnished after the 20th day but before the 101st day.

Paragraph (1) of section 1813(b) provides that the inpatient hospital deductible is $40 for any spell of illness (and is therefore $20 for any diagnostic study) beginning before 1969.

Paragraph (2) of section 1813(b) provides that the Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which is to be applicable in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. The inpatient hospital deductible will 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 year in which the promulgation is

made, to (B) the current average per diem rate for 1966. Any amount determined by the multiplication under this paragraph which is not a multiple of $4 will 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).

If, for example, the cost experience reviewed for purposes of the promulgation to be made in 1970 shows that the average per diem rate for inpatient hospital services during 1969 was $44.55 as compared to $39.80 in 1966, the amount of the deductible applicable in 1971 would be $44 ($40 multiplied by $\frac{\$44.55}{\$39.80}$ and then rounded to the nearest multiple of $4).

The current average per diem rate for any year will be determined by the Secretary on the basis of the best information available to him as to the amounts paid under part A for inpatient hospital services plus the amounts which would have been paid but for the inpatient hospital deductibles required under section 1813(a)(1).

SECTION 1814. CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of requests and certifications

Section 1814(a) provides that, except in the case of emergency hospital services (described in section 1814(d)), payment for covered services may be made only to providers of services which have an agreement with the Secretary entered into in accordance with section 1866 and only if the requirements of section 1814(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1814(a) requires that a written request (signed by the individual who receives the services or by another person when it is impracticable for him to do so) be filed for such payment under regulations to be issued by the Secretary.

Paragraph (2) of section 1814(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient hospital services received during a continuous period) that—

(A) in the case of inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services), the services were required to be given on an inpatient basis for medical treatment, or inpatient diagnostic study was medically required;

(B) in the case of inpatient psychiatric hospital services, the services 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 such treatment could reasonably be expected to improve the condition or inpatient diagnostic study was medically required;

(C) in the case of inpatient tuberculosis hospital services, the services were required to be given on an inpatient basis by or under the supervision of a physician for the treatment of tuberculosis, and the treatment can be reasonably expected to improve the condition or render it noncommunicable;

(D) in the case of posthospital extended care services, the services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis for a condition for which he was hospitalized prior to transfer to the extended care facility, or which arose while receiving such care for such a condition;

(E) in the case of posthospital home health services, the services were required because the individual was confined to his home (except when receiving services referred to in section 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would qualify as inpatient services if the institution met certain specified requirements) or posthospital extended care services, and the services were furnished while the individual was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(F) in the case of outpatient hospital diagnostic services, the services were required for diagnostic study.

Under the last sentence of section 1814(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) would be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1814(a) provides that, in the case of inpatient psychiatric hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving intensive treatment services, services necessary for diagnostic study, or similar services.

Paragraph (4) of section 1814(a) provides that, in the case of inpatient tuberculosis hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Paragraph (5) of section 1814(a) provides that payment may not be made for inpatient hospital services furnished an individual after the 20th day of a continuous stay or for posthospital extended care services furnished continuously after a period of time prescribed in regulations if the Secretary, before such individual's admission to the hospital or extended care facility, has rendered an adverse decision under section 1866(d) after a finding that the hospital or extended care facility is not making the necessary utilization reviews of long-stay cases.

Paragraph (6) of section 1814(a) provides that payment may not be made for inpatient hospital services or posthospital extended care services furnished an individual during a continuous period after a finding (as described in sec. 1861(k)(4)) by the physican members of the appropriate utilization review committee that further inpatient hospital services or posthospital extended care services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the third day after the day the

notice of such finding is received by the hospital or extended care facility.

Reasonable cost of services

Section 1814(b) provides that the amount to be paid any provider for services under part A is the reasonable cost of such services (subject to the deductibles under sec. 1813), as determined under section 1861(v) (discussed below).

No payments to Federal providers of services

Section 1814(c) provides that no payment is to be made to a Federal provider of services, except for emergency services, unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency. Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Payments for emergency hospital services

Section 1814(d) provides that payment may be made for emergency hospital services, in the absence of an agreement of the kind otherwise required between the Secretary and the hospital, to the extent that the Secretary would be required to make payment if the hospital had such an agreement in effect and otherwise meets the conditions of payment. (See sec. 1861(e) for the definition of a hospital eligible under this provision.) The hospital would have to agree, as a condition of payment under this provision, not to charge the patient for the emergency services.

Payment for inpatient hospital services prior to notification of non-eligibility

Section 1814(e) provides that if a hospital has acted reasonably and in good faith in assuming that an individual was entitled to have payment made for impatient hospital services under part A, the hospital can receive payment for such services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 120 days of entitlement to inpatient hospital services in the spell of illness; and no payment may be made unless the hospital refunds any payment already obtained from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the sixth elapsed day after the day of his admission to the hospital (not counting Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1814(e) would constitute an overpayment to the individual (and could be recovered) under section 1870.

Payment for certain emergency hospital services furnished outside the United States

Section 1814(f) provides that the authority contained in section 1814(d), relating to payments for emergency hospital services, will be applicable to emergency hospital services furnished by a hospital located outside the United States if the individual was present in the United States at the time the emergency which necessitated

inpatient hospital services occurred and the hospital outside the United States was closer to, or substantially more accessible from, the place where the emergency arose than the nearest hospital within the individual's illness or injury and available for the treatment of the illness or injury.

SECTION 1815. PAYMENT TO PROVIDERS OF SERVICES

Section 1815 provides that the Secretary will determine the amounts to be paid to providers of services under part A (such amounts to be paid not less often than monthly) from the Federal Hospital Insurance Trust Fund. The provider must furnish such information as the Secretary may request in order to determine the amounts to be paid to the provider.

SECTION 1816. USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

Section 1816(a) provides that if any group or association of providers of services wishes to have payments under part A made through a national, State, or other public or private agency or organization and nominates an agency or organization for this purpose, the Secretary may enter into an agreement with the agency or organization providing for the determination (subject to such review by the Secretary as may be provided for in the agreement) of the amounts to be paid under part A to such providers, and for the payment to such providers of the amounts so determined. The agreement could also include provision for the agency or organization to do all or any part of the following: (1) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records and otherwise to qualify as participants in the program; and (2) serve as a center for communications between the providers covered under the agreement and the Secretary, make such audits of the records of such providers as may be necessary to assure proper payment, and perform such other functions as are necessary to carry out section 1816(a).

Section 1816(b) provides that the Secretary is not to enter into an agreement with an agency or organization under section 1816(a) unless (1) he finds that (A) to do so is consistent with effective and efficient administration, (B) the agency or organization is willing and able to assist the providers in the application of safeguards against unnecessary utilization of services (and the agreement provides for such assistance), and (2) the agency or organization agrees to furnish to the Secretary such information acquired by it in carrying out its agreement as the Secretary may find necessary to perform his functions under part A.

Section 1816(c) provides that an agreement with an agency or organization under section 1816(a) may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the agency or organization for making payments to providers of services. Such an agreement will also provide for payment to the agency or organization of the necessary and proper costs of carrying out its functions performed or to be performed under the terms of the agreement.

Section 1816(d) provides that if the nomination of an agency or organization is made by a group or association of providers of services,

it will not be binding on members of such group or association which notify the Secretary of their election to that effect. Any provider may, upon notice, 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 either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary under section 1816(a) if the Secretary and such agency or organization agree to it.

Section 1816(e) provides that an agreement with the Secretary under section 1816(a) may be terminated by the agency or organization at such time and upon such notice as may be provided in regulations. An agreement may also be terminated by the Secretary at such time and upon such notice as may be provided in regulations, but only if he finds (after reasonable notice and opportunity for hearing) that the agency or organization has failed substantially to carry out the agreement or that the continuation of the agreement is disadvantageous or is inconsistent with the efficient administration of part A.

Section 1816(f) provides that an agreement with any agency or organization under section 1816(a) may require any of its officers or employees who are participating in carrying out the agreement to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1816(g) provides that no individual designated pursuant to such an agreement as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1816(g) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

Paragraph (3) of section 1816(g) provides that no agency or organization will be liable to the United States for any payments referred to in paragraph (1) or (2).

SECTION 1817. FEDERAL HOSPITAL INSURANCE TRUST FUND

Section 1817(a) creates the Federal Hospital Insurance Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part A. For the fiscal year ending June 30, 1966, and for each fiscal year thereafter, there are appropriated to the trust fund amounts equal to (1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 on wages reported to the Secretary of the Treasury after December 31, 1965, and (2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 on self-employment income reported to the Secretary of the Treasury on tax returns. These wages and self-employment income are to be certified by the Secretary of Health, Education, and Welfare on the basis of records established and maintained by him in accordance with such reports and returns. The amounts to be appropriated, which will be determined by the Secretary of the Treasury on the basis of estimates of the taxes, are to be transferred from time to time from the general fund of the Treasury to the trust fund, with adjustments being made for prior estimates which were greater or lesser than the taxes.

Section 1817(b) creates the Board of Trustees of the trust fund, to be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Board of Trustees will meet at least once each calendar year. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the trust fund; (2) report to the Congress by March 1 of each year on the operation and status of the trust fund for the preceding fiscal year and on its expected operation and status for the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes 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 those policies, including necessary changes in the provisions of the law which govern the way in which the trust fund is to be managed. The report on the status and operation of the trust fund is to include a statement of the assets of and disbursements from the fund during the preceding year, an estimate of income and disbursements for the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the trust fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1817(c) provides that it is the duty of the Managing Trustee to invest the portion of the trust fund which, in his judgment, is not required to meet current withdrawals. These 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. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the trust fund, of public-debt obligations having maturities fixed with due regard for the needs of the trust fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of 1 percent, the rate of interest will be the multiple of one-eighth of 1 percent nearest such market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1817(d) provides that any obligations acquired by the trust fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the trust fund, which may be redeemed at par plus accrued interest.

Section 1817(e) provides that the interest on and proceeds from the sale of any obligations held in the trust fund will be credited to and form a part of the fund.

Paragraph (1) of section 1817(f) directs the Managing Trustee 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) of the Internal Revenue Code of 1954 which are subject to refund under section 6413(c) of the Code with respect to wages paid after December 31, 1965. Such taxes are to 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 Code, and the Secretary of Health, Education, and Welfare will furnish the Managing Trustee such information as may be required for this purpose. The payments are to be covered into the Treasury as repayments to the account for refunding internal revenue collections.

Paragraph (2) of section 1817(f) provides that repayments under paragraph (1) will not be available for expenditures but will be carried to the surplus fund of the Treasury.

Section 1817(g) provides for the transfer at least once each fiscal year to the trust fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the trust fund from the railroad retirement account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the earnings record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1817(h) provides that the Managing Trustee will also 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 benefits provided by part A and the administrative expenses in accordance with section 201(g)(1) of the act.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

SECTION 1831. ESTABLISHMENT OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR THE AGED

Section 1831 establishes a voluntary medical insurance program for individuals aged 65 or over to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

SECTION 1832. SCOPE OF BENEFITS

Section 1832(a) provides that the benefits made available to an individual under the insurance program established by part B consist of—

(1) entitlement to have payment made to him or on his behalf for medical and other health services not furnished by (or under arrangements with) a provider of services (such as a hospital or home health agency); and

(2) entitlement to have payment made on his behalf for (A) home health services for up to 100 visits during a calendar year (without regard to whether or not the individual has been in a hospital); and (B) medical and other health services (other than physicians' services unless furnished by a resident or intern of a hospital or unless such services are in the field of pathology, radiology, physiatry, or anesthesiology) furnished by a provider of services (or by others under arrangements with them).

Section 1832(b) contains a cross reference to the definitions of "spell of illness", "medical and other health services", and other terms used in part B which are found in section 1861.

SECTION 1833. PAYMENT OF BENEFITS

Section 1833(a) provides for the amount of payment that will be made from the Federal Supplementary Medical Insurance Trust Fund in the case of each individual covered under the insurance program established by part B who incurs expenses for services.

Paragraph (1) of section 1833(a) provides that payment will be made for 80 percent of the reasonable charges for medical and other health services described in section 1832(a)(1); 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 part B on behalf of individuals enrolled in such organization if it undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any deductible amounts payable by them as a result of section 1833(b).

Paragraph (2) of section 1833(a) provides that payment will be made for 80 percent of the reasonable cost (as determined under sec. 1861(v)) of home health services and medical and other health services described in section 1832(a)(2).

Section 1833(b) provides that, before any payment is made by the program for covered expenses incurred by an individual during any calendar year, the individual must meet a deductible of $50. However, the deductible for any year will be reduced by the amount of any expenses which the individual incurred in the last 3 months of the preceding calendar year and which were applied toward the $50 deductible in such preceding year; the amount of any deductible imposed under section 1813(a)(2)(A) with respect to outpatient hospital diagnostic services furnished in any year will be regarded as an incurred expense under part B for such year. For example, in 1967–68 if the total amount of the outpatient hospital diagnostic services is $30, under part A the individual pays the first $20 and then 20 percent of the remaining $10, or a total of $22; the $20 is then considered as an incurred expense for part B.

Section 1833(c) provides that (notwithstanding any other provision of part B) expenses incurred in any calendar year for the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time will be considered as incurred expenses for purposes of section 1833 (a) and (b) only to the extent of $312.50 or 62½ percent of the expenses, whichever is smaller. When the 80-percent coinsurance under section 1833(a) is applied to these limits, the actual dollar amount which can be paid under part B for such outpatient psychiatric expenses is $250 or 50 percent of the charges, whichever is less (subject to the deductible under sec. 1833(b) unless other expenses have been used to satisfy it).

Section 1833(d) provides that payment may not be made under part B for services furnished an individual if such individual is entitled (or would be entitled except that the expenses involved were used in satisfying a deductible or a reduction under sec. 1813) to have payment made for those services under part A.

Section 1833(e) provides that no payment will be made under part B unless the information necessary to determine the amounts due has been furnished.

SECTION 1834. DURATION OF SERVICES

Section 1834(a) provides that payment may not be made under part B for home health services furnished an individual during any calendar year after such services have been furnished to him for 100 visits during the year. The charging of visits in connection with the provision of covered home health items and services for this purpose is to be determined in accordance with regulations.

Section 1834(b) provides that home health services will be taken into account for purposes of the limits on duration of coverage prescribed in section 1834(a) only if payment under part B is made or would be made if the services had been furnished within such limits and the request and certification requirements described in section 1835(a) had been met for such services.

SECTION 1835. PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

Section 1835(a) provides that payment for the services described in section 1832(a)(2) (home health services and medical and other health services) may be made only to providers of services which have an agreement with the Secretary under section 1866 and only if the requirements of section 1835(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1835(a) requires that a written request (signed by the individual who received the services or by another person when it is impracticable for him to do so) be filed for such payment under regulations issued by the Secretary.

Paragraph (2) of section 1835(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations) that—

(A) in the case of home health services, the services were required because the individual was confined to his home (except when receiving services referred to in sec. 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, and the services were furnished while the individual is or was under the care of a physician and under a plan established and reviewed periodically by a physician; and

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

Under the last sentence of section 1835(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) will be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Section 1835(b) provides that no payment is to be made under part B to a Federal provider of services unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency (St. Elizabeths Hospital in Wash-

ington, D.C., for example). Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

SECTION 1836. ELIGIBLE INDIVIDUALS

Section 1836 provides that every individual who has attained the age of 65 and is a resident of the United States, and is a citizen or is an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 10 years immediately preceding the month he applies for enrollment, is eligible to enroll in the insurance program established by part B. (However, section 104(b)(2) of the bill provides that a person convicted of certain offenses related to the national security may not enroll under part B.)

SECTION 1837. ENROLLMENT PERIODS

Section 1837(a) provides that an individual may enroll in the insurance program established by part B only in such manner and form as may be prescribed in regulations, and only during an enrollment period described in section 1837.

Paragraph (1) of section 1837(b) provides that no individual may enroll for the first time under part B more than 3 years after the close of the first enrollment period during which he could have enrolled.

Paragraph (2) of section 1837(b) provides that an individual whose enrollment under part B has terminated may not enroll for a second time unless he does so in a general enrollment period (as provided in sec. 1837(e)) which begins within 3 years after the effective date of such termination. No individual may enroll under part B more than twice.

Section 1837(c) provides that the initial general enrollment period is to begin on April 1, 1966, and is to end on September 30, 1966. This initial general enrollment period is open to individuals who meet the eligibility requirements of section 1836 before July 1, 1966.

Section 1837(d) provides that the initial enrollment period for an individual who first meets the eligibility requirements of section 1836 on or after July 1, 1966, is to begin on the first day of the third month before the month in which he first meets the eligibility requirements and is to end 7 months later. For example, if a resident citizen becomes 65 in April 1967, his enrollment period begins with January 1, 1967, and ends with July 31, 1967.

Section 1837(e) provides that there is to be a general enrollment period from October 1 to December 31 of each even-numbered year beginning with 1968.

SECTION 1838. COVERAGE PERIOD

Section 1838(a) provides that an individual's coverage period (the period during which he is entitled to benefits under the insurance program established by pt. B and the period for which premiums are due) will begin on whichever of the following is the latest:

(1) January 1, 1967; or

(2)(A) in the case of an individual who enrolls pursuant to section 1837(d) before the month in which he first satisfies the eligibility requirements of section 1836, the first day of such month; or

(B) in the case of an individual who enrolls pursuant to section 1837(d) in the month in which he first satisfies the eligibility requirements of section 1836, 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 section 1837(d) in the month following the month in which he first satisfies the eligibility requirements of section 1836, 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 section 1837(d) more than 1 month following the month in which he first satisfies the eligibility requirements of section 1836, 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 section 1837(e), the July 1 following the month in which he so enrolls.

Section 1838(b) provides that an individual's coverage period will continue until his enrollment has been terminated (1) by the filing of notice, during a general enrollment period, that he no longer wishes to participate in the program, or (2) for nonpayment of premiums. The termination of a coverage period by the filing of such a notice will take effect at the close of December 31 of the year in which the notice is filed; a termination for nonpayment of premiums will take effect on a date determined under regulations, which may provide a grace period of up to 90 days during which overdue premiums may be paid and the coverage period continued.

Section 1838(c) provides that payment may be made under part B only for expenses incurred by an individual during his coverage period.

SECTION 1839. AMOUNTS OF PREMIUMS

Section 1839(a) provides that the monthly premium for each individual enrolled under part B for each month before 1969 is to be $3.

Paragraph (1) of section 1839(b) provides that for each month after 1968 the amount of the monthly premium of each individual enrolled under part B will be determined under paragraph (2).

Paragraph (2) of section 1839(b) provides that the Secretary, between July 1 and October 1 of 1968 and of each even-numbered year thereafter, will determine and promulgate the dollar amount which is to be applicable for premiums for months occurring in the 2 succeeding calendar years. Such dollar amount will be the amount the Secretary estimates to be necessary so that the aggregate premiums for such 2 succeeding calendar years will equal one-half of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for the 2 succeeding years. In estimating aggregate benefits payable for any period, the Secretary will include an appropriate amount for a contingency margin.

Section 1839(c) provides that in the case of an individual whose coverage period begins pursuant to an enrollment after his initial enrollment period (as determined by sec. 1837 (c) or (d)), the monthly premium determined under section 1839(b) will 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 these purposes there will 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 indi-

vidual 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.

Section 1839(d) provides that if any monthly premium determined under the preceding provisions of section 1839 is not a multiple of 10 cents, it is to be rounded to the nearest multiple of 10 cents.

SECTION 1840. PAYMENT OF PREMIUMS

Paragraph (1) of section 1840(a) provides that the monthly premium of an individual who is entitled to monthly social security benefits under section 202 is to be collected (except as provided in subsec. (d)) by deducting the premium from the amount of such benefits. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary.

Paragraph (2) of section 1840(a) provides that the Secretary of the Treasury is to transfer periodically from the Federal Old-Age and Survivors Insurance Trust Fund, and from the Federal Disability Insurance Trust Fund (for example, for premiums deducted in the case of a woman aged 65 or over entitled to benefits as the wife of a disability beneficiary under age 65), to the Federal Supplementary Medical Insurance Trust Fund, the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Secretary of Health, Education, and Welfare and will be adjusted to the extent that prior transfers were too great or too small.

Paragraph (1) of section 1840(b) provides that the monthly premium of an individual who is entitled to receive an annuity or pension for a month under the Railroad Retirement Act of 1937 is to be collected (except as provided in subsec. (d)) by deducting the premium from such annuity or pension. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary (prescribed after consultation with the Railroad Retirement Board).

Paragraph (2) of section 1840(b) provides that the Secretary of the Treasury is to transfer periodically from the railroad retirement account to the Federal Supplementary Medical Insurance Trust Fund the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Railroad Retirement Board and will be adjusted to the extent that prior transfers were too great or too small.

Section 1840(c) provides that if an individual is entitled both to monthly social security benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under part B, or if he becomes simultaneously entitled both to such benefits and such annuity or pension after he enrolls, section 1840(a) will apply (i.e., the deduction for premiums will be made from his social security benefits); except that in the latter case, if the first month for which he was entitled to social security benefits was later than the first month for which he was entitled to a railroad retirement annuity or pension, then section 1840(b) will apply (i.e., the deduction for premiums will continue to be made from such annuity or pension).

Section 1840(d) provides that if an individual estimates that the amount which will be available for deduction under section 1840 (a) or (b) for any premium payment period will be less than the amount of the monthly premiums during that period, so that his premiums

could not be deducted from his benefits on a month-to-month basis, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires. For example, if an individual has earnings such that under the retirement test no cash social security benefits are payable to him during a year, he can pay his premiums over the course of the year (in accordance with regulations) rather than having them collected from future benefits.

Paragraph (1) of section 1840(e) provides that in the case of an individual receiving an annuity under the Civil Service Retirement Act or under another act administered by the Civil Service Commission, which provides retirement or survivorship protection, to whom neither section 1840(a) nor 1840(b) applies, his monthly premiums under part B will, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the premium amount from each installment of the annuity. If an annuitant agrees, such a deduction will also be made in the case of his spouse to whom neither section 1840(a) nor 1840(b) applies. The deduction will be made in such manner and at such times as the Civil Service Commission may determine and the Commission will furnish such information as the Secretary of Health, Education, and Welfare may reasonably request to carry out his functions with respect to the annuitants and their spouses.

Paragraph (2) of section 1840(e) provides that the Secretary of the Treasury is to transfer periodically but not less often than quarterly 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 total amount deducted under paragraph (1). Such transfer is to be made on the basis of a certification by the Civil Service Commission and will be adjusted to the extent that prior transfers were too great or too small.

Section 1840(f) provides that in the case of an individual who participates in the insurance program established by part B but to whom none of the preceding provisions of section 1840 (other than subsec. (d)) applies (i.e., who is not a social security, a railroad retirement, or a Federal civil service beneficiary), the premiums are to be paid to the Secretary at such times and in such manner as may be prescribed by regulations.

Section 1840(g) provides that amounts paid to the Secretary under section 1840 (d) or (f) are to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

Section 1840(h) provides that the premiums for an individual enrolled under part B will 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 period ends.

SECTION 1841. FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Section 1841(a) creates the Federal Supplementary Medical Insurance Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part B.

Section 1841(b) creates the Board of Trustees of the trust fund, which is to meet at least once each calendar year and will be composed of the Secretary of the Treasury, the Secretary of Labor, and the

Secretary of Health, Education, and Welfare. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the trust fund; (2) report to the Congress by March 1 of each year on the operation and status of the trust fund for 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 believes 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 therein, including necessary changes in the provisions of the law which govern the way in which the trust fund is to be managed. The report on the status and operation of the trust fund is to include a statement of the assets of and disbursements from the fund during the preceding year, an estimate of income and disbursements during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the trust fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1841(c) provides that it is the duty of the Managing Trustee to invest the portion of the trust fund which, in his judgment, is not required to meet current withdrawals. These 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. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the trust fund, of public-debt obligations having maturities fixed with due regard for the needs of the trust fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of 1 percent, the rate of interest will be the multiple of one-eighth of 1 percent nearest such market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1841(d) provides that any obligations acquired by the trust fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the trust fund, which may be redeemed at par plus accrued interest.

Section 1841(e) provides that the interest on and proceeds from the sale of any obligations held in the trust fund will be credited to and form a part of the fund.

Section 1841(f) provides for the transfer at least once each fiscal year to the trust fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary of Health, Education, and Welfare as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the trust fund from the railroad retirement account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These

amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the earnings record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1841(g) provides that the Managing Trustee will 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 part B and the payments for administrative expenses in accordance with section 201(g)(1) of the act.

Section 1841(h) provides that the Managing Trustee will also 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. Such certified amount will be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

SECTION 1842. USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

Section 1842(a) provides that in order to carry out the administration of the voluntary medical insurance program established by part B with maximum efficiency and convenience for individuals entitled to benefits under part B 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 part B, the Secretary is authorized to enter into contracts with carriers (including carriers with which agreements under sec. 1816 are in effect) which will undertake to perform some or all of the functions listed in paragraphs (1) through (4) of section 1842(a) or, to the extent provided in the contracts, to secure performance of such functions by other organizations. With respect to the functions which involve payments for physicians' services, the Secretary will to the extent possible enter into contracts with carriers.

Paragraph (1) of section 1842(a) provides that the carriers under contract (or such other organizations) will (A) make determinations of the rates and amounts of payments required pursuant to part B to be made to providers of services and other persons on a reasonable cost or reasonable charge basis, whichever applies; (B) receive, disburse, and account for funds in making such payments; and (C) make audits of the records of providers of services necessary to assure that proper payments are made to them under part B.

Paragraph (2) of section 1842(a) provides that the carriers will determine compliance with the requirements of section 1861(k) as to utilization review, and assist providers and other persons who furnish services for which payment may be made under part B in the development of procedures relating to utilization practices, make studies of the effectiveness of utilization procedures, assist in the application of safeguards against unnecessary utilization of services furnished by providers and other persons to individuals entitled to benefits under part B, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of sec. 1861(k)(2)) to make reviews of utilization.

Paragraph (3) of section 1842(a) provides that the carriers will serve as a channel of communication of information relating to the administration of the voluntary medical insurance program under part B.

Paragraph (4) of section 1842(a) provides that the carriers will assist in discharging other necessary administrative duties, as may be provided in the contract.

Paragraph (1) of section 1842(b) provides that 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.

Paragraph (2) of section 1842(b) provides that the Secretary is not to enter into a contract with a carrier unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements relating to financial responsibility, legal authority, and other matters as he finds pertinent.

Paragraph (3) of section 1842(b) provides that each contract must provide that the carrier will—

(A) take necessary action to assure that, where payment under part B for a service is on a cost basis, the cost is reasonable cost (as determined under sec. 1861(v));

(B) take necessary action to assure that, where payment under part B for a service is on a charge basis, 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 such payment will be made on the basis of a receipted bill, or on the basis of an assignment under which the reasonable charge is the full charge for the service;

(C) establish and maintain procedures under which an individual enrolled under part B will be entitled to a fair hearing by the carrier when request for payment is denied or is not acted upon with reasonable promptness or when the amount of payment is in controversy;

(D) furnish to the Secretary such timely information and reports as may be necessary for the Secretary to perform his functions under part B; and

(E) maintain and afford access to whatever records 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 part B.

Each contract shall also contain such other terms and conditions consistent with section 1842 as the Secretary may find necessary or appropriate. In determing the reasonable charge for services for section 1842(b)(3) there will 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.

Paragraph (4) of section 1842(b) provides that each contract must be for the term of at least 1 year, and may be made automatically renewable unless either party provides notice of intent to terminate the contract at the end of its current term. However, the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying it out in a manner inconsistent

with the efficient and effective administration of the insurance program established by part B.

Section 1842(c) provides that each contract is to provide for advances of funds to the carrier for the making of payments by it under part B, and for payment of the necessary and proper administrative costs of the carrier.

Section 1842(d) provides that any contract may require a 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.

Paragraph (1) of section 1842(e) provides that no individual designated pursuant to a contract as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1842(e) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

Paragraph (3) of section 1842(e) provides that no carrier will be liable to the United States for any payments referred to in paragraph (1) or (2).

Section 1842(f) provides that, for purposes of part B, the term "carrier" means (1) with respect to providers of services and other persons, a voluntary association, corporation, or 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 (1)) with which an agreement is in effect under section 1816.

SECTION 1843. STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

Section 1843(a) provides that the Secretary, at the request of a State made before January 1, 1968, will enter into an agreement with such State to provide coverage under part B for all eligible individuals who are in a coverage group elected by the State from the two groups described in section 1843(b). (For definition of "eligible individual" see sec. 1836, discussed above.)

Section 1843(b) provides that the agreement entered into with any State under section 1843(a) may be applicable to either of the following groups: (1) aged recipients of money payments under a plan of the State approved under title I or XVI, or (2) aged recipients of money payments under all of the plans of the State approved under titles I, IV, X, XIV, and XVI. However, neither group may include any individual entitled to monthly OASDI benefits or entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(c) provides that, for purposes of section 1843, coverage under the agreement may be provided only for an individual who is an eligible individual (as described above) on the date the agreement is entered into or who becomes an eligible individual in the period between the date of the agreement and January 1, 1968. He will be treated as a money payment recipient if he receives a money payment for the month in which the agreement is entered into or any month between such month and January 1968.

Section 1843(d) provides that in the case of any individual enrolled pursuant to an agreement under section 1843—

(1) the monthly premium to be paid by the State is to be determined under section 1839 (without any increase under subsec. (c) thereof);

(2) his coverage period will begin either on January 1, 1967, on the first day of the third month following the month in which the State agreement is entered into, on the first day of the first month in which he is both an eligible individual and a member of the coverage group specified in the agreement, or on a date (not later than January 1, 1968) specified in the agreement, whichever is the latest; and

(3) his coverage period will end on either the last day of the month in which he is determined by the State to have become ineligible for the money payments specified in the agreement, or the last day of the month before 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.

Section 1843(e) provides that any individual whose coverage period attributable to the State agreement is terminated (as described in sec. 1843(d)(3)) will be deemed for purposes of part B (including the continuation of his coverage period) to have enrolled under section 1837 in the initial general enrollment period (ending September 30, 1966) provided by section 1837(c).

Section 1843(f) provides that with respect to individuals receiving money payments under a State plan approved under title I, IV, X, XIV, or XVI, if the agreement so provides, the term "carrier" as defined in section 1842(f) also includes the State agency specified in the agreement which administers or supervises the administration of the State plan approved under title I, XVI, or XIX. Thus, a State agency which meets the definition of "carrier" under section 1843(f) could be considered a carrier with respect to all individuals receiving the specified money payments (including those who are not eligible to be in the coverage group as defined in sec. 1843(b) because they are entitled to monthly social security benefits or a pension or annuity under the railroad retirement system). The agreement with the State will also contain provisions to facilitate the financial transactions of the State and the carrier relating to deductions and coinsurance, in the interest of economy and efficiency of operation, with respect to individuals receiving money payments under the State's plans approved under titles I, IV, X, XIV, and XVI.

SECTION 1844. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

Section 1844(a) authorizes the appropriation from time to time of a Government contribution, equal to the total premiums payable by individuals who have enrolled under part B, from the Treasury to the Federal Supplementary Medical Insurance Trust Fund.

Section 1844(b) provides that in order to assure prompt payment of benefits and administrative expenses under part B during the early months of the program, and to provide a contingency reserve, there is also authorized to be appropriated for repayable advances (without interest) to the trust fund, an amount (to remain available through calendar year 1968) equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in January 1967 by the insurance program established by part B if they had theretofore enrolled.

PART C—MISCELLANEOUS PROVISIONS

SECTION 1861. DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

Section 1861 defines, for purposes of both part A and part B, the terms used in the new title XVIII.

Spell of illness

Section 1861(a) defines the term "spell of illness" to mean a period of consecutive days (1) beginning with the first day (not included in a previous spell) on which the individual is furnished inpatient hospital or extended care services and 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 throughout which he is neither an inpatient of a hospital nor an inpatient of an extended care facility. (For special definitions of "hospital" and "extended care facility" for purposes of sec. 1861(a)(2), see discussion of secs. 1861(e) and 1861(j) below.)

Inpatient hospital services

Section 1861(b) defines the term "inpatient hospital services" to mean the following items and services furnished to an inpatient of a hospital (and furnished by the hospital, except as provided in item (3)): (1) bed and board; (2) such nursing services, use of hospital facilities, medical social services, and 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; (3) other diagnostic or therapeutic items or services ordinarily furnished by the hospital or by others under arrangements made by the hospital. Excluded from the term "inpatient hospital services" are the services of a private-duty nurse or attendant and medical or surgical services provided by a physician, resident, or intern (other than services provided in the field of pathology, radiology, physiatry, or anesthesiology); except that services of a resident-in-training or intern provided under a teaching program approved by the American Medical Association or the American Osteopathic Association and services of a resident-in-training or an intern in the field of dentistry

provided under a program approved by the American Dental Association are included in the term.

Inpatient psychiatric hospital services

Section 1861(c) defines the term "inpatient psychiatric hospital services" to mean inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient tuberculosis hospital services

Section 1861(d) defines the term "inpatient tuberculosis hospital services" to mean inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

Section 1861(e) defines the term "hospital" to mean in general an institution which (1) is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care, or rehabilitation services for injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires that every patient be under the care of a physician; (5) provides 24-hour nursing service rendered by or under the supervision of a registered nurse; (6) has in effect a hospital utilization review plan satisfying section 1861(k); (7) in the case of an institution in any State which provides for licensing of hospitals, is licensed (or approved) by the licensing agency pursuant to State or local law; and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety (except that these requirements may not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals).

For the specific purpose of determining how long an individual is out of a hospital in order to establish when a spell of illness ends, an institution satisfying item (1) of the definition is a "hospital." In determining whether emergency hospital services are covered under section 1814, subsections (d) or (f), and for purposes of describing the institution from which an individual must be transferred in order to be eligible for posthospital extended care or posthospital home health services, an institution satisfying items (1), (2), (3), (4), (5), and (7) of the definition is a "hospital." The term "hospital" does not (except for purposes of determining when a spell of illness ends) 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 section 1861(g) or a psychiatric hospital as defined in section 1861(f). The term "hospital" also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Mass., but payment may be made with respect to services provided by or in such a sanatorium only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Psychiatric hospital

Section 1861(f) defines the term "psychiatric hospital" to mean 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 prescribed for hospitals under items (3) through (8) of section 1861(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. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Tuberculosis hospital

Section 1861(g) defines the term "tuberculosis hospital" to mean 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 prescribed for hospitals under items (3) through (8) of section 1861(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 under the insurance program established by part A; (4) meets such staffing requirements as the Secretary may find 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. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Extended care services

Section 1861(h) defines the term "extended care services" to mean the following items and services furnished to an inpatient of an extended care facility (and furnished by such facility except as provided in items (3) and (6)): (1) nursing care furnished by or under the supervision of a registered nurse; (2) bed and board; (3) physical, occupational, or speech therapy furnished by the facility or others under arrangements with them; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment as are ordinarily furnished by the facility for care and treatment of inpatients; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which such facility has in effect a transfer agreement and certain other services provided by such a hospital; and (7) such other health services as are generally provided by extended care facilities. Any service which would not be covered if furnished to an inpatient of a hospital is excluded.

Posthospital extended care services

Section 1861(i) defines the term "posthospital extended care services" to mean extended care services (as defined in sec. 1861(h))

furnished an individual after transfer from a hospital of which he was an inpatient for not less than 3 consecutive days before his discharge. Items and services will be deemed to have been furnished to an individual after transfer from a hospital, and he will be deemed to have been an inpatient of the hospital immediately before transfer, if he is admitted to the extended care facility within 14 days after discharge from such hospital. An individual will be deemed not to have been discharged from an extended care facility if he is readmitted to such facility or any other extended care facility within 14 days after discharge therefrom.

Extended care facility

Section 1861(j) defines the term "extended care facility" to mean an institution (or a distinct part thereof) which has a transfer agreement with one or more participating hospitals (as described in sec. 1861(l)) and which (1) is primarily engaged in providing to inpatients skilled nursing care and related services, or rehabilitation services; (2) has policies which are developed with the advice of and periodically reviewed by a professional group (including at least one physician and at least one registered nurse) to govern the services it provides; (3) has a physician, registered nurse, or medical staff responsible for the execution of such policies; (4) requires that the health care of each patient be under the supervision of a physician and provides for having a physician available to furnish necessary emergency medical care; (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 registered professional nurse employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan satisfying section 1861(k); (9) is licensed (or meets the standards for licensing) pursuant to State or local law; and (10) meets such other conditions relating to health and safety or physical facilities as the Secretary may find necessary. The term "extended care facility" does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For the specific purpose of determining when a spell of illness ends (under sec. 1861(a)(2)) the term includes any institution which satisfies item (1). The term "extended care facility" also includes an institution or distinct part of an institution operated or listed and certified as a Christian Science nursing home by the First Church of Christ, Scientist, Boston, Mass., but payment may be made with respect to services ordinarily provided by or in such a nursing home only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Utilization review

Section 1861(k) provides that a utilization review plan of a hospital or extended care facility will be considered sufficient if it is applicable to services furnished to individuals entitled to benefits under title XVIII and if it provides (1) for the review, on a sample or other basis, of admissions, duration of stays, and professional services from the standpoint of medical necessity and for the purpose of promoting the most efficient use of available health facilities and services; (2) for such review to be made by a staff committee of the institution which includes two or more physicians, or by a similarly

composed group outside the institution which is established either by the local medical society and some or all of the hospitals and extended care facilities in the locality or in some other manner which may be approved by the Secretary; (3) for such review (in each case of a continuous stay of extended duration in a hospital or extended care facility) as of such days of such stay (which may be different for different classes of cases) as may be specified in regulations, with such review being made as promptly as possible after each day specified in the regulations but no later than 1 week following that day; and (4) for prompt notification to the institution, the individual, and his physician of any finding (which shall be made only after opportunity for consultation has been provided the physician) that further stay in the institution is not medically necessary. The utilization review plan must provide for review by a group outside the institution where, because of its small size (or, in the case of an extended care facility, because of lack of an organized medical staff), or for such other reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee.

Agreements for transfer between extended care facilities and hospitals

Section 1861(l) provides that a hospital and an extended care facility will be considered to have a transfer agreement if a written agreement between them (or a written undertaking by the person or body controlling them, in the case of institutions under common control) provides reasonable assurance that (1) there will be timely transfer of patients between the institutions whenever it is determined medically appropriate by the attending physician; and (2) there will be timely transfer between the institutions of medical and other information needed for patients' care or for determining whether patients can be adequately cared for in some other way. Any extended care facility which does not have a transfer agreement in effect, but which is found by a State agency (with which an agreement under sec. 1864 is in effect) or by the Secretary if there is no such agreement) to have attempted in good faith to enter into such an agreement with a hospital close enough to the facility to make transfer of patients and information between them feasible, will be considered to have a transfer agreement in effect if the agency (or the Secretary) 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 benefits under title XVIII.

Home health services

Section 1861(m) defines the term "home health services" to mean the following items and services furnished to an individual who is under the care of a physician, on a visiting basis in his residence (except as provided in item (7)), by a home health agency (or by others under arrangements with such agency) under a plan established and periodically reviewed by a physician: (1) part-time or intermittent nursing care provided by or under the supervision of a registered 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 home health aid services; (5) medical supplies (other than drugs and biologicals) and the use of medical appliances; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which

the agency is affiliated; and (7) any of the foregoing items and services which (A) 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 meeting such standards as may be prescribed in regulations, and (B) involved the use of equipment of such nature that the items and services cannot readily be made available to the individual in his place of residence, or are furnished at such facility while he is there to receive any item or service involving the use of such equipment (but excluding transportation of the individual in connection with such items or services). Any item or service which would not be covered if furnished to an inpatient of a hospital is excluded.

Posthospital home health services

Section 1861(n) defines the term "posthospital home health services" to mean home health services (as defined in sec. 1861(m)) which (1) are furnished an individual within 1 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 1 year after his most recent discharge from an extended care facility of which he was an inpatient entitled to benefits under part A, and (2) are covered by a plan (described above) established within 14 days after his discharge from the hospital or extended care facility.

Home health agency

Section 1861(o) defines the term "home health agency" to mean a public agency or private organization (or a part of such agency or organization) which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional group (including at least one physician and at least one registered nurse) to govern services, and provides for supervision of such services by a physician or a registered nurse; (3) maintains clinical records on all patients; (4) is licensed (or meets standards for licensing) pursuant to State or local law; and (5) meets other conditions found by the Secretary to be necessary for health and safety. The term does not include a private organization which is not a nonprofit organization exempt from Federal income taxation unless it is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed by regulations. For purposes of part A, the term does not include any agency or organization which is primarily for the care and treatment of mental diseases. The term "home health agency" also includes a Christian Science visiting nurse service operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., but payment may be made with respect to services ordinarily furnished by such visiting nurse service only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Outpatient hospital diagnostic services

Section 1861(p) defines the term "outpatient hospital diagnostic services" to mean diagnostic services which are ordinarily furnished to outpatients for purposes of diagnostic study by the hospital or by others under arrangements made by the hospital, and which are furnished in facilities supervised by the hospital or its organized medical

staff. The term excludes any services which would not be covered if furnished to an inpatient of a hospital.

Physicians' services

Section 1861(q) defines the term "physicians' services" to mean professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not services provided by an intern or resident-in-training under a teaching program approved as described in sec. 1861(b)).

Physician

Section 1861(r) defines the term "physician" to mean (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery (including osteopathy), and (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 surgery related to the jaw or the reduction of any fracture of the jaw or any facial bone.

Medical and other health services

Section 1861(s) defines the term "medical and other health services" to mean any of the following items or services (unless such services are otherwise classified as inpatient hospital, extended care, or home health services): (1) physicians', chiropractors', and podiatrists' 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 services, of kinds which are commonly furnished in physicians' offices and either rendered without charge or included in the physicians' bills, and hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients; (3) diagnostic X-ray 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 the patient's 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 the patient's physical condition changes).

Paragraphs (10) and (11) of section 1861(s) provide that no diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital will be included in paragraph (3) unless such laboratory: (A) if situated in any State in which State or applicable local law provides for their licensing, is licensed pursuant to such law or approved as meeting licensing standards by the agency of such State or locality responsible for licensing them; and (B) 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

Section 1861(t) defines the term "drugs" and the term "biologicals" to mean (except for purposes of the exclusion of drugs and biologicals under home health services) (1) those drugs and biologicals which are included or are 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); (2) combinations of drugs or biologicals if the principal ingredient or ingredients of the combinations meet the conditions specified in clause (1); or (3) which are approved for use in the hospital by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing them.

Provider of services

Section 1861(u) defines the term "provider of services" to mean a hospital, extended care facility, or home health agency.

Reasonable cost

Paragraph (1) of section 1861(v) provides that the reasonable cost of any services is to be determined under 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 will be considered the reasonable cost of such services. In prescribing these regulations the Secretary must consider, among other things, the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of services on account of services furnished to individuals by such providers. Such regulations may provide for determination of the cost 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 must take into account both direct and indirect costs of providers in order that the costs with respect to individuals covered by the insurance programs established by title XVIII will not be borne by individuals not so covered and the costs with respect to individuals not covered will not be borne by the insurance programs. The regulations must also provide for making retroactive corrective adjustments where, for any provider of services for any fiscal period, the total reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

Paragraph (2) of section 1861(v) provides that if a patient receives inpatient services in accommodations which are more expensive than semiprivate accommodations, but which are not medically necessary, the amount of payment may not exceed an amount equal to the reasonable cost of such services if furnished in semiprivate accommodations. If a patient receives other items or services which are more expensive than those for which payment can be made, the Secretary will take into account for purposes of payment no more than the reasonable cost of the services that can be paid for.

Paragraph (3) of section 1861(v) provides that if a patient is placed in accommodations less expensive than semiprivate accommodations for a reason the Secretary determines is not consistent with the program's purpose (and not at the patient's request), payment will be limited to the reasonable cost of semiprivate accommodations minus the difference between the customary charges for semiprivate accommodations and the accommodations furnished.

Paragraph (4) of section 1861(v) defines the term "semiprivate accommodations" to mean two-bed, three-bed, or four-bed accommodations.

Arrangements for certain services

Section 1861(w) provides that the term "arrangements" is limited to arrangements under which receipt of payment by a participating provider of services discharges all financial liability for the services.

State and United States

Section 1861(x) provides that the terms "State" and "United States" have the same meaning as when used in title II of the Social Security Act (i.e., the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa).

Chiropractors' and podiatrists' services

Paragraph (1) of section 1861(y) provides that the term "chiropractor" means an individual who is licensed under State law to practice as a chiropractor in the State; and the term "chiropractors' services" means services performed by a chiropractor within the scope of his license.

Paragraph (2) of 1861(y) provides that the term "podiatrist" means an individual who is licensed under State law to practice as a podiatrist in the State; and the term "podiatrists' services" means services performed by a podiatrist within the scope of his license.

SECTION 1862. EXCLUSIONS FROM COVERAGE

Section 1862(a) provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) 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 (because of such individual's membership in a prepayment plan or for some other reason) has a legal obligation to provide or to pay for; (3) which are paid for directly or indirectly by a governmental entity (other than under the Social Security Act or under a health benefits or insurance plan established for employees of such 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 conditions described in sec. 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

(including contact lenses), 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 the 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 the teeth.

Section 1862(b) provides that no payment may be made under part A or part B for any item or service for which payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State. Any payment under part A or part B with respect to any item or service must be conditioned on reimbursement being made to the appropriate trust fund for such payment if and when notice or other information is received that payment for such item or service has been made under such a law or plan.

SECTION 1863. CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

Section 1863 provides that the Secretary is to consult with the Health Insurance Benefits Advisory Council (established by sec. 1867), appropriate State agencies, and national listing or accrediting bodies, and may consult with local agencies, in prescribing such conditions for participation for providers of services as may be necessary for health and safety. The conditions may be varied for different areas or classes of institutions, and may be set higher for the institutions or agencies in a particular State at such State's request (but, in the case of hospitals, not higher than the accreditation requirements of the Joint Commission on Accreditation of Hospitals).

SECTION 1864. USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

Section 1864(a) provides that the Secretary is to make an agreement with any State which is able and willing to enter into an agreement to utilize the services of the State health agency or other appropriate State agencies (or the appropriate local agencies) for the purpose of determining which institutions and agencies qualify to participate in the programs under title XVIII and whether laboratories meet the requirements of subparagraphs (10) and (11) of section 1861(s). The Secretary may accept a State (or local) agency's findings as to the qualifications of an institution or agency to participate. The Secretary may also, pursuant to agreement, use State and local agencies to do any of the following: (1) provide consultative services to institutions or agencies to assist them in establishing and maintaing fiscal records or otherwise qualifying for participation, or in providing information necessary to determine what benefits are payable; and (2) provide consultative services to institutions, agencies, or organizations to assist

them in establishing and evaluating the effectiveness of utilization review procedures.

Section 1864(b) provides that the Secretary is to pay the State for the reasonable costs of the administrative activities performed under its agreement under section 1864(a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to 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.

SECTION 1865. EFFECT OF ACCREDITATION

Section 1865 provides that any hospital accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all the requirements in the definition of "hospital" in section 1861(e) except the utilization review requirement. If the Joint Commission requires a utilization review plan (or imposes another requirement serving the same purpose) for accreditation, the Secretary is authorized to find that accredited hospitals meet all the requirements in such definition. The Secretary may also accept the findings of the American Osteopathic Association, or any other national accrediting body, as to the eligibility of institutions and agencies to participate if he finds reasonable assurance that the pertinent requirements of section 1861 are met.

SECTION 1866. AGREEMENTS WITH PROVIDERS OF SERVICES

Paragraph (1) of section 1866(a) provides that any provider of services will be eligible to participate and eligible for payments under title XVIII if it files an agreement with the Secretary not to charge for covered services (except as provided in paragraph (2)) and to make adequate provision for refund of erroneous charges.

Paragraph (2) of section 1866(a) provides that a provider of services may charge an individual the following: (A) the amount of any deductible imposed pursuant to section 1813 (a)(1), (a)(2), or (a)(4) or section 1833(b), and in addition an amount equal to 20 percent of the reasonable charges for the items and services furnished (not in excess of 20 percent of the amount customarily charged for such items and services by the 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 (except that, in the case of 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, the provider may charge the proportion which is appropriate under the limits imposed by sec. 1833(c)); (B) the excess amount of more expensive services and items furnished at the request of the individual; and (C) the cost of the first 3 pints of whole blood furnished during a spell of illness; except that a charge may not be made for the cost of the administration of such blood and no charge can be made if the blood has been replaced on the individual's behalf or arrangements have been made for its replacement. To illustrate the latter pro-

vision (taken together with the provisions of sec. 1813(a)(3)): if a hospital were to charge a beneficiary $25 for a pint of blood which cost the hospital $10 (and which was one of the first 3 pints of blood furnished the beneficiary in the spell of illness), the program would not pay the hospital the $10 cost of the blood but there would be deducted from payments otherwise due the hospital the difference between the $10 cost and the $25 charge—i.e., $15; thus, if the hospital collected the $25 from the beneficiary, the hospital would receive no more in payments from the patient and the program than if it had charged the beneficiary only the $10 cost of the blood.

Section 1866(b) provides that an agreement with a provider of services under section 1866(a) may be terminated by the provider at such time and upon such public notice as may be prescribed by regulations. The Secretary could require the agreement to remain in effect for up to 6 months after the provider gives notice. The Secretary may terminate such an agreement if he determines that the provider (A) is not complying with the agreement or the law, (B) is no longer qualified to participate, or (C) has failed to provide data to determine whether payments are due the provider or the amount of such payments, or has refused access to its records for verification. The termination of any agreement with a provider is to be applicable with respect to (1) inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), or posthospital extended care services furnished to an individual admitted on or after the effective date of termination, (2) home health services furnished under a plan established on or after the effective date of termination or, if the plan is established before the effective date, services furnished after the calendar year in which the termination is effective, and (3) any other items or services furnished on or after the effective date of termination.

Section 1866(c) provides that if the Secretary terminates an agreement, the provider may not file a new agreement unless the Secretary finds that the reason or reasons for termination is or are removed and that there is assurance they will not recur.

Section 1866(d) provides that if the Secretary finds that timely reviews of long-stay cases are not being made by a hospital or extended care facility he may, in lieu of terminating the agreement, deny payment for services furnished an individual after the 20th day of continuous inpatient hospital care or after stays of a prescribed length in an extended care facility. Such a decision denying payment for services may be made only after notice to the provider and the public and will be rescinded when the Secretary finds that the reviews are being made and that there is assurance they will continue to be made. The Secretary may not make any decision denying such payment except after reasonable notice and opportunity for hearing.

SECTION 1867. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Section 1867 provides for the creation of a Health Insurance Benefits Advisory Council to advise the Secretary on general policy in the administration of title XVIII and in the formulation of regulations thereunder. The Council is to consist of 16 persons, who are not Federal employees, to be appointed by the Secretary. The Secretary will from time to time appoint one of the members to serve as Chairman. The Council is to include people 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. The members are to serve 4-year terms and may not serve continuously for more than two consecutive terms. The Secretary may appoint such special advisory professional or technical committees as may be useful. The Council members and members of any advisory or technical committee will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day). The Council is to meet as frequently as the Secretary finds necessary, but he must call a meeting upon request of four members.

SECTION 1868. NATIONAL MEDICAL REVIEW COMMITTEE

Section 1868(a) provides for the creation of a National Medical Review Committee. The Committee is to consist of nine persons, who are not Federal employees, to be appointed by the Secretary. The members are to be selected from among representatives 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; at least one member must be representative of the general public and a majority of the members must be physicians. The members are to hold office for 3-year terms and may not serve continuously for more than two terms.

Section 1868(b) provides that the Committee members will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day).

Section 1868(c) provides that it is the Committee's function to study the utilization of hospital and other medical care and services for which payment can be made under part A or part B with a view to recommending any changes which may seem desirable in the utilization of care and services or the administration of the programs, or in the provisions of title XVIII. The Committee is to make to the Secretary (who is to transmit it promptly to the Congress) an annual report including any recommendations the Committee may have.

Section 1868(d) authorizes the Committee to engage any technical assistance required to carry out its functions. It also provides that the Secretary is to make available the secretarial, clerical, and other assistance and data needed by the Committee.

SECTION 1869. DETERMINATIONS; APPEALS

Section 1869(a) provides that determinations of entitlement to benefits under part A and part B, and of the amount of benefits under part A, are to be made by the Secretary in accordance with regulations.

Section 1869(b) provides that any individual dissatisfied with any determination under section 1869(a) as to entitlement under part A or part B, or as to amount of benefits under part A if the matter in controversy is $1,000 or more, will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g) of the act.

Section 1869(c) provides that any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination terminating an agreement under section 1866(b)(2), will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g).

SECTION 1870. OVERPAYMENTS ON BEHALF OF INDIVIDUALS

Section 1870(a) provides that any payment under part A or part B to a provider of services or other person with respect to items or services furnished an individual will be considered as a payment to such individual.

Section 1870(b) provides that where the Secretary finds that an overpayment is made to a provider of services or other person and cannot be recouped from such provider or person, or payment is made under the conditions specified in section 1814(e) for an individual who is not entitled to have such payment made, proper adjustment or recovery will be made under regulations prescribed by the Secretary after consultation with the Railroad Retirement Board. The Secretary will make the proper adjustment or recovery by (A) decreasing any payment under title II of the Social Security Act or under the Railroad Retirement Act of 1937, as the case may be, to which such individual is entitled, or (B) requiring such individual or his estate to refund the amount in excess of the correct amount, or (C) decreasing any payment under title II of the Social Security Act or under the Railroad Retirement Act of 1937, as the case may be, payable to the estate of such individual or to any other person on the basis of the wages and self-employment income (or compensation) which were the basis of the payments to such individual, or (D) by applying any combination of the foregoing. As soon as practicable after any such adjustment or recovery is determined to be necessary, the Secretary (for purposes of sec. 1870 and sec. 1841(f)) will certify (to the Railroad Retirement Board if adjustment is to be made by decreasing cash payments under the Railroad Retirement Act of 1937) the amount of the overpayment with respect to which the adjustment or recovery is to be made.

Section 1870(c) provides there will be no adjustment as provided in section 1870(b) of payments to, or recovery from, any person who is without fault, if such adjustment or recovery would defeat the purposes of title II of the Social Security Act or the Railroad Retirement Act or would be against equity and good conscience.

Section 1870(d) provides that no certifying or disbursing officer will be liabile for overpayments where adjustment or recovery is waived or is not completed prior to the death of all persons against whose benefits the adjustment is authorized.

SECTION 1871. REGULATIONS

Section 1871 provides that the Secretary will prescribe the regulations necessary to carry out the administration of the new insurance programs under title XVIII. When used in such title the term "regulations" means (unless the context otherwise requires) regulations prescribed by the Secretary.

SECTION 1872. APPLICATION OF CERTAIN PROVISIONS OF TITLE II

Section 1872 provides that sections 206, 208, 216(j), and 205 (a), (d), (e), (f), (h), (i), (j), (k), and (l) of the act will apply to title XVIII as they do to title II.

SECTION 1873. DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

Section 1873 provides that any designation made in title XVIII, by name, of any nongovernmental organization or publication will not be affected by a change of the name of such organization or publication and will apply to any successor organization or publication which the Secretary finds serves the purpose for which the designation was made.

SECTION 1874. ADMINISTRATION

Section 1874(a) provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform any of his functions directly or by contract.

Section 1874(b) provides that the Secretary may contract with any person, agency, or institution to secure such special data and actuarial and other information as may be necessary in carrying out his functions.

SECTION 1875. STUDIES AND RECOMMENDATIONS

Section 1875(a) provides that the Secretary is to make studies and develop recommendations to be submitted to the Congress relating to the health care of the aged, including studies and recommendations concerning the adequacy of existing personnel and facilities for health care for purposes of the programs under title XVIII; methods for encouraging further development of efficient and economical alternatives to inpatient hospital care; and the effect of the deductibles and coinsurance provisions upon beneficiaries, providers of health services, and the financing of the program.

Section 1875(b) instructs the Secretary to make a continuing study of the operation and administration of the insurance programs under title XVIII and to submit to the Congress annually a report concerning the operation of such programs.

SECTION 102(b). GRACE PERIOD UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 102(b) of the bill provides that if an individual was eligible to enroll under the supplementary medical insurance program under part B of the new title XVIII before October 1, 1966, but failed to do so before such date, and it is shown to the satisfaction of the Secretary that there was good cause for such failure to enroll, such individual may enroll in the supplementary medical insurance program at any time before April 1, 1967. The Secretary will by regulation determine what constitutes good cause. The coverage period (within the meaning of sec. 1838 of the Social Security Act) of an individual enrolling under this provision will begin on the first day of the sixth month after the month in which he enrolls.

SECTION 103. TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

Section 103(a) of the bill provides that anyone who—

(1) has attained age 65 before 1968 (or has earned three quarters of coverage for each calendar year after 1965 and before the year of attainment of age 65);

(2) is not entitled to hospital insurance benefits (and would not be entitled to such benefits upon filing application for monthly benefits under section 202 of the Social Security Act), and is not certifiable as a qualified railroad retirement beneficiary (see sec. 105 of the bill, discussed below);

(3) is a resident of the United States, and is (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously for at least 10 years immediately prior to the month in which he files application under section 103; and

(4) has filed an application under section 103 in accordance with regulations,

will be entitled to benefits under part A of title XVIII beginning with the first month (after June 1966) in which he meets these requirements and ending with the month he dies or, if earlier, the month before the month in which he becomes eligible for hospital insurance benefits under section 226 or becomes certifiable as a railroad retirement beneficiary.

Any person who would have met the preceding requirements in any month if he had filed an application before the end of that month will be deemed to have met such requirements for that month if he files an application before the end of the next 12 months. No application will be accepted as a valid application under section 103 if it is filed more than 3 months before the first month in which the individual meets the requirement of paragraphs (1), (2), and (3) above; i.e., an application filed prematurely will not prevent the individual from obtaining benefits under section 103 if he qualifies therefor at a later time.

Section 103(b) of the bill provides that section 103(a) does not apply to any person who is covered under the Federal Employees Health Benefits Act of 1959 or any person who (as of the time of his application under sec. 103(a)) is a member of any organization referred to in section 210(a)(17) of the Social Security Act (relating to subversive organizations) or has been convicted of any offense listed in section 202(u) of such act.

Section 103(c) authorizes the appropriation to the Federal Hospital Insurance Trust Fund of such sums as the Secretary deems necessary for any fiscal year on account of payments made or to be made during such fiscal year under part A of title XVIII of the Social Security Act with respect to individuals who are entitled to benefits thereunder solely by reason of section 103 of the bill and on account of the additional administrative expenses resulting or expected to result from such payments and any loss of interest to the fund resulting from such payments.

SECTION 104. SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Paragraph (1) of section 104(a) of the bill amends section 202(t) of the Social Security Act (relating to suspension of benefits for certain aliens outside the United States) by adding a new paragraph which provides that an individual is not entitled to benefits under part A of title XVIII for any month for which his cash social security benefits are suspended under such section.

Paragraph (2) of section 104(a) of the bill amends section 202(u) of the Social Security Act so that the penalty which may be imposed thereunder upon a conviction for subversive activities (namely, the elimination of all earnings credits for the calendar quarter in which the conviction occurs and prior quarters) will apply to a determination of entitlement to benefits under part A of title XVIII, as well as to the determination of entitlement to cash benefits under title II as provided in existing law.

Paragraph (1) of section 104(b) of the bill provides that payments may not be made under part B of title XVIII for expenses incurred by an individual for any month for which he may not be paid cash benefits under title II by reason of section 202(t) (relating to suspension of benefits for certain aliens who are outside the United States).

Paragraph (2) of section 104(b) of the bill provides that an individual convicted of any of the offenses stipulated in section 202(u) of the Social Security Act may not enroll under part B of title XVIII.

SECTION 105. RAILROAD RETIREMENT AMENDMENTS

Paragraph (1) of section 105(a) of the bill adds a new section 21 to the Railroad Retirement Act of 1937 to provide that, in order to make available hospital insurance benefits under part A of title XVIII of the Social Security Act (added by sec. 102 of the bill) for annuitants, pensioners, and certain other aged individuals under the railroad retirement system, the Railroad Retirement Board is to certify to the Secretary of Health, Education, and Welfare, upon the Secretary's request, the name of any individual who has attained age 65 and—

(1) is entitled to an annuity or pension under the Railroad Retirement Act, or

(2) would be entitled to an annuity under such act if he (or, in the case of a spouse, the spouse's husband or wife) had stopped working in employment covered under such act and applied for such annuity, or

(3) bears a relationship to an employee which by reason of section 3(e) of such act (providing a minimum for the amounts of railroad retirement annuities which is based on the social security benefit formula) has been, or would be, taken into account in calculating the amount of the annuity of such employee or his survivors.

The certification made by the Board to the Secretary of Health, Education, and Welfare is to include such additional information as may be necessary to carry out the hospital insurance benefit provisions, and will be effective on the date of certification or on such earlier date (not more than 1 year prior to the date of certification) as the Board specifies as the date on which the individual first met the requirements

for certification. The Board is to notify the Secretary of the date on which the individual no longer meets the requirements.

Paragraph (2) of section 105(a) of the bill provides that, for purposes of section 21 of the Railroad Retirement Act of 1937 (and secs. 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 is deemed to include entitlement under the Railroad Retirement Act of 1935.

Section 105(b) of the bill amends sections 3201, 3211, and 3221(b) of the Railroad Retirement Tax Act (ch. 22 of the Internal Revenue Code of 1954), relating to the rate of tax on employees, on employee representatives, and on employers, respectively. The amendments change the references to section 3101 of the code in those sections to section 3101(a) to conform to the amendment to section 3101 made by section 321(b) of the bill. A clarifying change is made in each such section by adding a specific reference to the rate of tax (2¾ percent) provided under the Social Security Amendments of 1956. The amendments made by section 105(b) are effective with respect to compensation for services rendered after December 31, 1965.

Section 105(c) of the bill contains a cross reference to section 326 of the bill, which amends the Railroad Retirement Act of 1937 to preserve the existing relationship between the railroad retirement and old-age, survivors, and disability insurance systems.

SECTION 106. MEDICAL EXPENSE DEDUCTION

Section 106 of the bill as passed by the House consisted of five subsections. Section 106(a) of such bill revised section 213(a) of the Internal Revenue Code of 1954 (relating to allowance of deduction for medical expenses). Section 106(b) of such bill revised section 213(b) of the code (relating to the limitation with respect to medicine and drugs). Section 106(c) of such bill amended section 213(e) of the code (relating to definition of medical care). Section 106(d) of such bill revised section 213(g) of the code (which provides for an increased maximum limitation on the medical expense deduction if the taxpayer or his spouse has attained age 65 and is disabled). Section 106(e) of such bill provided an effective date for the amendments made by such section.

Subsections (a) and (b) of section 106 of the bill as passed by the House have been deleted, and subsections (c), (d), and (e) of such section have been changed as hereafter mentioned.

Definition of medical care

Section 106(c) of the bill as passed by the House is renumbered as section 106(a). The renumbered section 106(a) of the bill strikes out paragraph (1) of section 213(e) of the code (which defines medical care to mean 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 (including amounts paid for accident or health insurance), or (B) for transportation primarily for and essential to medical care described in (A)) and replaces it with new paragraphs (1), (2), and (3). The existing paragraph (2) is renumbered as paragraph (4). No change is made in the wording of the definition of medical care except as it relates to amounts paid for insurance.

Under the new paragraph (1), subparagraphs (A) and (B) are the same as existing law except for the elimination of the phrase "including amounts paid for accident or health insurance." Under the new subparagraph (C), amounts paid for an insurance contract are included within the definition of medical care only to the extent that the premiums are attributable to insurance covering medical care (as defined in subpars. (A) and (B) of sec. 213(e)(1)). In determining whether a contract constitutes an "insurance" contract, it is irrelevant whether the benefits are payable in cash or services. Under the new paragraph (1)(C), it is made clear that premiums paid under part B of title XVIII of the Social Security Act (relating to supplementary medical insurance for the aged) are amounts paid for insurance. Taxes paid under section 1401 (relating to tax on self-employment income) or under section 3101 (relating to tax on income of employees) of the Internal Revenue Code do not constitute amounts paid for insurance.

New paragraph (2) of section 213(e) is revised to provide that if amounts are payable under an insurance contract for other than medical care (such as an indemnity for loss of income or for loss of life, limb, or sight) then no amount paid for such contract is to be treated as medical care unless (1) either the contract or a separate written statement furnished to the policyholder specifies what part of the premium is attributable to insurance for medical care, and (2) the part of the premium specified as being so attributable is a reasonable amount in relation to the total premium under the contract. Moreover, the amount to be treated as expenses for medical care in such a case is not to exceed the amount so specified.

Certain prepaid insurance

Under the new paragraph (3) added to section 213(e) of the code, subject to the limitations of the new paragraph (2), premiums paid during a taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 are to 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—

(1) for a period of 10 years or more, or

(2) until the year in which the taxpayer attains age 65 (but in no case for a period of less than 5 years).

Maximum limitation in certain cases

Section 106(d) of the bill as passed by the House is renumbered as section 106(b). The renumbered section 106(b) of the bill amends section 213(g) of the code (which provides for an increased maximum limitation on the medical expense deduction allowable to a taxpayer who has attained the age of 65 and is disabled or whose spouse has attained the age of 65 and is disabled) to eliminate the requirement of attaining age 65 so that the increased maximum limitation is applicable in any case where either the taxpayer or his spouse is disabled.

Effective date

Section 106(e) of the bill as passed by the House is renumbered as section 106(c). The renumbered section 106(c) provides that the amendments made by section 106 shall apply to taxable years beginning after December 31, 1966.

SECTION 107. RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

Section 107 of the bill amends section 6051(c) of the Internal Revenue Code of 1954 to provide that the statement (form W–2) furnished to an employee pursuant to section 6051 of the code must show the proportion of the amounts 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.

SECTION 108. TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

Paragraph (1) of section 108(a) of the bill amends section 201(a)(3) of the Social Security Act to exclude the taxes imposed on employers and employees for hospital insurance under sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954, as amended by section 321 of the bill, from the employer and employee taxes appropriated to the Federal old-age and survivors insurance trust fund.

Paragraph (2) of section 108(a) of the bill amends section 201(a)(4) of the act to exclude the taxes imposed on the self-employed for hospital insurance under section 1401(b) of the code, as amended by section 321 of the bill, from the self-employment taxes appropriated to the Federal old-age and survivors insurance trust fund.

Paragraph (3) of section 108(a) of the bill amends section 201(g)(1) of the act, relating to payments from the trust funds to the Treasury as reimbursement for administrative costs of title II of the act and chapters 2 and 21 of the Internal Revenue Code of 1954.

The new subparagraph (A) of section 201(g)(1) provides for payment from any or all of the trust funds (which include for this purpose 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) of the costs to the Department of Health, Education, and Welfare of administering titles II and XVIII of the act and for adjustments during, and after the close of, each fiscal year among the trust funds so that each fund bears its proportionate share of the costs of administering titles II and XVIII.

The new subparagraph (B) of section 201(g)(1) provides for payments from the trust funds to the Treasury to meet the estimated quarterly costs to the Treasury of the administration of titles II and XVIII of the act and of chapters 2 and 21 of the Internal Revenue Code of 1954.

Paragraph (4) of section 108(a) of the bill amends section 201(g)(2) of the act to specify that in estimating the amount of employee taxes subject to refund the managing trustee of the old-age, survivors, and disability insurance trust funds shall consider only the taxes imposed for the support of the old-age and survivors insurance and disability insurance programs. (This provision conforms with the provisions of the new section 1817(f) of the act for estimating amounts of employee taxes imposed for the hospital insurance program that are subject to refund because of overpayment.)

Paragraph (5) of section 108(a) of the bill amends section 201(h) of the act to specify that payments made under the new section 226 of the act (relating to entitlement to hospital insurance benefits) are

not to be made from the Federal old-age and survivors insurance trust fund.

Section 108(b) of the bill amends section 218(h)(1) of the act (relating to the depositing in the trust funds of amounts received by the Secretary of the Treasury under agreements for coverage of State and local government employees) to provide for proportionate deposits in the Federal hospital insurance trust fund as well as in the existing trust funds.

Section 108(c) of the bill amends section 1106(b) of the act so that the two new insurance trust funds established by the bill, like the old-age, survivors, and disability insurance trust funds, may be reimbursed for costs of furnishing information (disclosure of which is authorized by regulations) or services to individuals or organizations.

SECTION 109. ADVISORY COUNCIL ON SOCIAL SECURITY

Section 109 of the bill replaces the existing provision for the appointment of Advisory Councils on Social Security Financing with a new provision for the appointment of Advisory Councils on Social Security.

Section 109(a) of the bill adds a new section 706 to title VII of the Social Security Act to provide for the appointment by the Secretary of Health, Education, and Welfare of an Advisory Council on Social Security in 1968 and every fifth year thereafter to review the status of the four named trust funds in relation to the long-term commitments of the old-age, survivors, and disability insurance program, the hospital insurance program, and the supplementary medical insurance program and to review also 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. Each Council is to consist of the Commissioner of Social Security, as chairman, and 12 members who will, to the extent possible, represent organizations of employers and employees in equal numbers, and self-employed persons and the public. The Councils are authorized to engage technical assistance, including actuarial services, and the Secretary is required to make available to the Council secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as the Council might require. While serving on business of the Council, the members of the Council will receive compensation at rates fixed by the Secretary but not exceeding $100 per day, and, while serving away from their homes or regular places of business, they will be allowed travel expenses, including per diem in lieu of subsistence. Each Council is to make reports of its findings and recommendations to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees of each of the four trust funds not later than January 1 of the second year after the year in which it was appointed, and then will cease to exist. Separate reports are required with respect to (1) the old-age, survivors, and disability insurance program, (2) the hospital insurance program, and (3) the supplementary medical insurance program.

Section 109(b) of the bill repeals section 116(e) of the Social Security Amendments of 1956 (which is the section that now provides for the appointment by the Secretary in 1966 and every fifth year thereafter of an Advisory Council on Social Security Financing with functions limited to review of the financing aspects of the program).

SECTION 110. MEANING OF TERM "SECRETARY"

Section 110 of the bill provides that, as used in the bill and in the provisions of the Social Security Act amended thereby, the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare.

SECTION 111. ADMINISTRATION OF HOSPITAL INSURANCE FOR THE AGED BY THE RAILROAD RETIREMENT BOARD

Sections 111(a) and 111(b) of the bill make necessary changes in the Social Security Act, the Federal Insurance Contributions Act, and the Health Insurance for the Aged Act required to conform to section 21 of the Railroad Retirement Act of 1937 (as added by the bill) and the Railroad Retirement Tax Act.

Section 111(a)(1) of the bill amends section 226(a)(2) of the Social Security Act by deleting the language which lists "a qualified railroad retirement beneficiary" as an individual entitled to hospital insurance benefits under part A of title XVIII.

Section 111(a)(2) of the bill amends section 226(b)(2) of the act by deleting the provisions specifying that an individual shall be deemed to be a qualified railroad retirement beneficiary for the month in which he died if he would have been a qualified railroad retirement beneficiary for such month had he died in the next month.

Section 111(a)(3) of the bill repeals section 226(c) of the act which defines the term "qualified railroad retirement beneficiary," and redesignates subsection (d) of such section 226 as subsection (c).

Section 111(a)(4) of the bill amends section 1811 of the act by deleting the language which includes individuals entitled to benefits under the railroad retirement system as persons whose entitlement to hospital insurance benefits would be established by section 226 of such act, as added by the bill.

Section 111(a)(5) of the bill amends subsections (a)(2) and (b)(2) of section 1813 of the act (containing provisions relating to deductibles applicable to payments for outpatient hospital diagnostic services and relating to the determination of the amount of the inpatient hospital deductible) by specifying that the provisions apply to individuals entitled to such benefits under the Railroad Retirement Act.

Section 111(a)(6) of the bill amends section 1817(g) of the act relating to the periodic transfer to the Federal Hospital Insurance Trust Fund from the social security trust funds and the Railroad Retirement Account of amounts certified as overpayments by the Secretary pursuant to section 1870(b) of the act, as added by the bill, by deleting the language providing for such transfers of funds from the Railroad Retirement Account to the Federal Hospital Insurance Trust Fund.

Section 111(a)(7) of the bill amends section 1841(f) of the act relating to the periodic transfer to the Federal Supplementary Medical Insurance Trust Fund from the social security trust funds and the Railroad Retirement Account of amounts certified as overpayments by the Secretary pursuant to section 1870(b) of the act, as added by the bill, so that the amounts recovered under subsection (g) of section 21 of the Railroad Retirement Act of 1937, as added by the bill, shall

be transferred from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund.

Section 111(a)(8) of the bill amends section 1870(b) of the act relating to the adjustment and recovery of overpayments to a provider of services or other persons for items or services furnished an individual, by deleting all references to the adjustment and recovery of such overpayments by decreasing payments under the railroad retirement program.

Section 111(a)(9) of the bill amends section 1870(c) of the act relating to the barring of adjustment or recovery of overpayments in the case of any person who is without fault, by deleting the language applying this provision to cases where such adjustment or recovery would defeat the purposes of the Railroad Retirement Act.

Section 111(a)(10) of the bill amends section 1874(a) of the act by specifying that the health insurance programs established by such title shall be administered by the Secretary, except as otherwise provided in title XVIII, by broadening the exception to include exceptions provided in the Railroad Retirement Act.

Section 111(b) of the bill amends section 103(a) of the bill, providing entitlement to hospital insurance benefits for certain persons not beneficiaries under the social security or railroad retirement programs, to substitute references to the new section 21(b) of the Railroad Retirement Act for references to a qualified railroad retirement beneficiary.

Section 111(c)(1) of the bill amends section 21 of the Railroad Retirement Act of 1937 as added by section 105 of the bill.

Subsection (a) of the new section 21 provides that the Railroad Retirement Board would have the same authority to make determinations as to the rights to hospital insurance benefits of the specified categories of individuals described in subsection (b) as the Secretary of Health, Education, and Welfare would have under section 226 of the Social Security Act with respect to individuals whose entitlement to hospital insurance benefits is determined under such section. The hospital insurance benefit provisions of part A of title XVIII of the Social Security Act would be applicable to individuals whose benefit rights are thus determined by the Railroad Retirement Board. Payments for services provided under the railroad retirement program could also be made to hospitals in Canada.

Subsection (b) of the new section 21 provides that an individual who has attained age 65 would be entitled to the same hospital insurance benefits as are provided under part A of title XVIII of the Social Security Act if he—

(1) is entitled to an annuity under the Railroad Retirement Act, or

(2) would be entitled to an annuity under such act if he (or, in the case of a spouse, the spouse's husband or wife) had stopped working in employment covered under such act and applied for such annuity, or

(3) had been awarded a pension under section 6, or

(4) bears a relationship to an employee which, by reason of section 3(e) of such act (providing a minimum for the amounts of railroad retirement annuities based on the social security benefit provisions), has been, or would be, taken into account in cal-

culating the amount of the annuity of such employee or his survivors.

Payments for the benefits provided would be made from the Railroad Retirement Account. Payments would be made for the cost of services furnished in Canada only to the extent that such payments exceed the amount payable under the law in effect in the place in Canada where such services are furnished.

Subsection (c) of the new section 21 contains provisions to prevent the duplication of payments where an individual is potentially entitled to hospital insurance benefits under both the social security and railroad retirement programs, and provides that the Railroad Retirement Board and the Secretary of Health, Education, and Welfare are to jointly establish procedures for determining which program has jurisdiction in such cases.

Subsection (d) of the new section 21 provides that any agreement entered into by the Secretary of Health, Education, and Welfare pursuant to part A or part C of title XVIII of the Social Security Act would also be entered into on behalf of the Railroad Retirement Board. However, the Railroad Retirement Board would have authority to enter into agreements with Canadian hospitals and hospitals devoted primarily to railroad employees, for the purpose of providing hospital insurance benefits for persons whose entitlement to such benefits is under section 21 of the Railroad Retirement Act.

Subsection (e) of the new section 21 provides that a request for payment for services filed under such section would be deemed to be a request for payment for services filed at the same time under section 226 and part A of title XVIII of the Social Security Act, and a request for payment filed under section 226, and part A of title XVIII of the Social Security Act, would be deemed also to be a request for payment for services filed at the same time under section 21 of the Railroad Retirement Act.

Subsection (f) of the new section 21 provides that the Railroad Retirement Board and the Secretary of Health, Education, and Welfare shall furnish each other such information, records, and documents as may be considered necessary for the administration of section 21, or section 226 and part A of title XVIII of the Social Security Act.

Subsection (g) of the new section 21 provides for the application of the provisions of section 1870 of the Social Security Act (on overpayments on behalf of individuals) as added by the bill and of section 9 of the Railroad Retirement Act (on erroneous payments) to payments made by the Railroad Retirement Board under section 21, or part B of title 18 of the Social Security Act, except that any recovery of overpayments under part B of title XVIII of the Social Security Act would be transferred to the Federal Supplementary Medical Insurance Trust Fund.

Subsection (h) of the new section 21 provides that for purposes of the new section 21 (and secs. 1840, 1843, and 1870 of the Social Security Act as added by the bill, relating to health insurance benefits for the aged) 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.

Subsection (i) of the new section 21 authorizes appropriations to the Railroad Retirement Account to cover the costs of payments made from the account under section 21 in cases where the Railroad Retirement Account is not reimbursed through the financial interchange pro-

visions of section 5(k)(2)(A)(iii) and where the individual on whose behalf the payment is made, but for his entitlements to such benefits under such section 21, would have been entitled to such benefits under section 103 of the Health Insurance for the Aged Act, title I of the bill (relating to eligibility of uninsured aged individual for hospital insurance benefits).

Section 111(c)(2) of the bill amends section 5(k)(2) of the Railroad Retirement Act, providing for transfers of funds between the Railroad Retirement Account and the social security trust funds, by deleting certain obsolete provisions of such section, and by applying the provisions for fund transfers to hospital insurance benefits. The transfers of funds with respect to hospital insurance benefits would operate like the transfers under present law with respect to old-age, survivors, and disability insurance benefits; i.e., the transfers would place the Federal Hospital Insurance Trust Fund in the position it would have been in if railroad employment had been covered under social security since January 1, 1937, the date the social security program went into effect.

Paragraphs (1), (2), and (3) of section 111(d) of the bill amend sections 3201, 3211, and 3221(b) of the Railroad Retirement Tax Act, as amended by the bill, relating respectively to the rate of tax on employees, employee representatives, and employers under the railroad retirement program, by providing for the taxation of railroad employment for hospital insurance benefit purposes under the Railroad Retirement Tax Act.

Section 111(d)(4) of the bill amends section 1401(b) of the Internal Revenue Code of 1954, relating to the rate of tax under the Self-Employment Contributions Act, by deleting the language providing for taxing railroad employee representatives, for purposes of the taxes of the hospital insurance benefits program, as self-employed persons.

Paragraphs (5) and (6) of section 111(d) of the bill amend sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 by deleting the language providing for the taxation of railroad employees, for purposes of the hospital insurance benefits tax, under the Federal Insurance Contributions Act.

Section 111(e) of the bill provides that the amendments made by section 111 of the bill would become effective on January 1, 1966, provided that as of October 1, 1965, the Railroad Retirement Tax Act provides that the maximum amount of monthly compensation taxable under such act for the following January is to be an amount equal to or in excess of one-twelfth of the maximum wages which the Federal Insurance Contributions Act provides may be counted for the calendar year beginning January 1, 1966, or effective on January 1 of any subsequent year if this requirement is met as of October 1 of the immediately preceding year.

SECTION 112. ADDITIONAL UNDER SECRETARY AND ASSISTANT SECRETARIES OF HEALTH, EDUCATION, AND WELFARE

Section 112 provides for three additional positions in the Department of Health, Education, and Welfare, an Under Secretary and two Assistant Secretaries.

The additional Under Secretary provided for in this section shall perform such duties as the Secretary may prescribe and shall serve as Secretary during the absence or disability of the Secretary and the Under Secretary now provided for, in accordance with directives of the Secretary. The provisions of section 2 of Reorganization Plan No. 1 of 1953 (67 Stat. 631) shall be applicable to such additional Assistant Secretaries, and the rates of compensation of the additional Under Secretary and Assistant Secretaries shall be the same as those now provided for those offices.

PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 121. ESTABLISHMENT OF PROGRAMS

Section 121(a) of the bill adds a new title XIX, providing grants to States for medical assistance programs, to the Social Security Act.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAM

SECTION 1901. APPROPRIATION

Section 1901 authorizes the appropriation for each fiscal year of a sum sufficient to carry out the purposes of title XIX, in order to enable each State (as far as practicable under the conditions in such State) to furnish medical assistance on behalf of aged, blind, or permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care. The sums made available under this section are to be used for making payments to States which have submitted and had approved State plans for medical assistance. (Sec. 1903(a) provides that such payments are to be made beginning with the quarter commencing January 1, 1966.)

SECTION 1902. STATE PLANS FOR MEDICAL ASSISTANCE

Section 1902(a) sets forth the requirements with which a State plan for medical assistance must comply in order to be approved by the Secretary of Health, Education, and Welfare and thereby qualify the State for payments under title XIX. To be approved, such a State plan must—

(1) provide that it will be in effect in all political subdivisions of the State and, if the plan is administered by the subdivisions, that it 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 Federal financial participation under section 1903 is authorized and, effective July 1, 1970, provide for State financial participation equal to all of such non-Federal share;

(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 not acted upon with reasonable promptness;

(4) provide methods of administration of the plan as found necessary by the Secretary for its proper and efficient operation; these would include (A) methods relating to the establishment and maintenance of personnel standards on a merit basis, with the Secretary being precluded from exercising any authority in connection with the selection, tenure, or compensation of any individual employed in accordance with these methods, and (B) provision for utilization of professional medical personnel in the administration of the plan, and in supervision of such administration where the plan is administered locally;

(5) provide that there be a single State agency to administer, or to supervise the administration of, the plan, except that eligibility for medical assistance under the plan shall be determined by the State or local agency administering the approved plan of the State for old-age assistance or for aid to the aged, blind, or disabled;

(6) provide that the State agency will make reports as required by the Secretary, and will comply with provisions found necessary by the Secretary to assure their correctness and verification;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the plan's administration;

(8) provide for affording all individuals who wish to do so an opportunity to apply for medical assistance under the plan and for furnishing such assistance with reasonable promptness to all applicants who are eligible for assistnace under the plan;

(9) provide—

(A) for a State authority or authorities with responsibility to establish and maintain standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services; and

(B) that, after June 30, 1967, the requirements under such standards shall include any such requirements in standards established by the Secretary relating to protection against fire and other hazards to the health and safety of individuals in such institutions;

(10) provide for making medical assistance available to all individuals receiving old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled under the State's plans approved under titles I, IV, X, XIV, and XVI of the act; and—

(A) provide that (except as to care and services described in section 1905(a)(4) or 1905(a)(14)) the medical assistance made available to individuals receiving aid or assistance under any one of such plans—

(i) will not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such plan; and

(ii) will 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 the plan under title XIX includes medical or remedial care and services for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide (except as to care and services described in section 1905(a)(4) or 1905(a)(14))—

(i) for making medical or remedial care and services available to all individuals who if needy would be eligible for aid or assistance under any such plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the cost of necessary medical or remedial care and services, and

(ii) that the medical or remedial care and services made available to all individuals who are not recipients under any such State plan will be equal in amount, duration, and scope;

(11) provide for entering into cooperative arrangements with the State agencies responsible for health and vocational rehabilitation services looking toward maximum utilization of these services in providing medical assistance under the plan;

(12) provide that in determining blindness an examination will be made either by a physician skilled in diseases of the eye or by an optometrist, as the individual may select;

(13) provide for inclusion of some institutional and some noninstitutional care and services and, as of July 1, 1967, for the inclusion of at least the items of care and services listed in clauses (1) through (5) of section 1905(a); and for the 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 on any individual with respect to in-patient hospital services furnished him under the plan, and

(B) any deduction, cost sharing, or similar charge imposed as to any other care or services furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, will be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or to his income and resources;

(15) in the case of eligible individuals 65 years of age or older covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary medical insurance benefits for the aged) established by the bill, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and

(B) where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual

under such supplementary medical insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources;

(16) include, to the extent required by regulations of the Secretary, provisions (conforming to such regulations) regarding the furnishing of medical assistance to eligible residents who are absent from the State;

(17) include reasonable standards, comparable for all groups, for determining eligibility for and the extent of medical assistance under the plan, which standards—

(A) are consistent with the objectives of title XIX,

(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 if he met the State's need requirements would be eligible for aid or assistance in the form of money payments under the State's 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 the amount of 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 unless such applicant or recipient is the individual's spouse or is his child who is under age 21 or, if the child is age 21 or over, 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 any other type of remedial care recognized under State law;

(18) provide that property liens will not be imposed, on account of medical assistance provided under the plan, during a recipent's lifetime (except pursuant to a judgment of a court on account of benefits incorrectly paid), and preclude adjustments or recovery of medical assistance correctly paid except from the estate of a recipient who was at least age 65 when he received such assistance, and then only after the death of his surviving spouse and at a time when he has no surviving child who is under 21, blind, or permanently and totally disabled;

(19) provide safeguards 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 or older who are patients in institutions for mental diseases—

(A) provide for agreements or other arrangements, with State authorities concerned with mental diseases and, where

appropriate, with such institutions, necessary for carrying out the State plan. These will include arrangements for joint planning and for development of alternate methods of care, for assuring immediate readmittance to institutions where needed for individuals under alternate plans of care, for providing for access to patients and facilities, and for submitting information and reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided is in his best interests, including assurances of initial and periodic review of his medical and other needs, of his receiving appropriate medical treatment within the institution, and of periodic determination of his need for continued institutional care;

(C) provide for the development of alternate plans of care with 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 to help such recipients and patients attain or retain capability for self-care or other services to prevent or reduce dependency which are appropriate; and for methods of administration necessary to assure that the State plan with respect to these recipients and 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 or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward a comprehensive mental health program; and

(22) describe (A) the kinds, numbers, and responsibilities of professional medical personnel and supporting staff used in the administration of the plan, (B) the standards used by State standard-setting authorities for institutions in which medical assistance recipients may receive care or services, (C) cooperative arrangements with State health and vocational rehabilitation agencies for maximum utilization and coordination of medical assistance with their services, and (D) other State standards and methods used to assure that medical or remedial care and services to medical assistance recipients are of high quality.'

Section 1902(a) also provides that, notwithstanding the requirement in paragraph (5) above, any State which (on January 1, 1965, and on the date it submits its plan under title XIX) administers or supervises its program for the blind under title X (or under title XVI, insofar as it relates to the blind) through a State agency other than the State agency that administers or supervises its title I plan (or title XVI plan, insofar as it relates to the aged) will be permitted, upon coming under title XIX, to retain such separate blind program agency to administer or supervise (as a separate State plan, except for purposes of paragraph (10) above) the portion of the approved plan for medical assistance under title XIX which relates to blind individuals.

Section 1902(b) requires the Secretary of Health, Education, and Welfare to approve any plan which fulfills the conditions specified in section 1902(a), except that he is not to 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 who meets the definition of a dependent child under title IV of the act disregarding the provisions of section 406(a)(2); or

(3) any residence requirement which excludes any individual residing in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

Section 1902(c) requires the Secretary, notwithstanding the fact that a State plan is otherwise approvable, not to approve such plan if he determines that its approval and operation will result in a reduction in aid or assistance (other than so much as is provided under the approved title XIX plan) provided for eligible individuals under the State's plan approved under title I, IV, X, XIV, or XVI.

SECTION 1903. PAYMENT TO STATES

Section 1903(a) provides for making Federal payments to States with respect to expenditures for programs of medical assistance under approved plans. Except as otherwise provided in section 1903 and in section 1117 (as added to title XI of the Social Security Act by sec. 405 of the bill), the Secretary will pay each State with an approved plan for medical assistance, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b)) of the total medical assistance expenditures during the quarter, including in such expenditures premiums under part B of title XVIII (relating to supplementary medical insurance benefits for the aged) for recipients for money payments under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or remedial care or the cost of such care; plus

(2) an amount equal to 75 percent of the amounts expended during the quarter for administrative costs attributable to compensation or training of skilled professional medical personnel and directly supporting staff of the State agency or local agency administering the plan; plus

(3) one-half of the remaining administrative expenses.

Section 1903(b) provides that, notwithstanding the provisions of section 1903(a), the amount of the Federal payment for any quarter attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases is to be paid only to the extent that total expenditures from Federal, State, and local funds for mental health services under State and local public health and public welfare programs for the quarter are shown to the satisfaction of the Secretary to exceed the average of the total expenditures for these services for each quarter of the fiscal year ending June 30, 1965. The expenditures for these services for each quarter in the fiscal year ending June 30, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination under section 1903(b); and expenditures for any quarter beginning after December 31, 1965, are to be determined on the basis of the latest data,

satisfactory to the Secretary, available to him at the time of the determination for such State for such quarter. For the purposes of section 1903(b), such determinations will be conclusive.

Section 1903(c) provides that if the Secretary finds, on the basis of satisfactory information submitted by a State, that its Federal medical assistance percentage applicable to any quarter during the period January 1, 1966, through June 30, 1969, is less than 105 percent of the Federal share of the State's medical expenditures during the fiscal year ending June 30, 1965, then its Federal medical assistance percentage will be 105 percent of such Federal share instead of the percentage determined under section 1905(b). Such adjusted percentage will be applicable for such quarter and each subsequent quarter in such period prior to the first quarter as to which such finding is not applicable.

For the above purposes, such Federal share means the percentage which the excess of—

(A) the total of the amounts of the Federal shares (determined under the applicable formulas of the public assistance titles of the act) of the State's expenditures for aid or assistance in any form during fiscal year 1965 under its plans approved under titles I, IV, X, XIV, and XVI over

(B) the total of the Federal shares determined under such formulas with respect to its expenditures of aid or assistance during such year, excluding aid or assistance in the form of medical or remedial care,

is of the total of aid or assistance expenditures in the form of medical or remedial care under such plans during such year.

Section 1903(d) provides procedures for paying to a State the amounts to which it is entitled under the preceding provisions of section 1903. These are, with appropriate modifications, similar to those under the existing public assistance titles of the act.

Section 1903(e) provides that payments under the preceding provisions of section 1903 are not to be made unless the State makes a satisfactory showing that it is making efforts toward broadening the scope of the care and services available under its plan and toward liberalizing the eligibility requirements for medical assistance, looking toward providing, on or before the first day of the calendar quarter following the 40-calendar quarter period that began with the first calendar quarter for which the plan is effective, comprehensive care and services to substantially all individuals who meet the plan's eligibility requirements with respect to income and resources, including services to help such individuals to attain independence or self-care.

SECTION 1904. OPERATION OF STATE PLANS

Section 1904 provides for withholding of Federal payments to a State if the Secretary finds, after reasonable notice and opportunity for hearing to the State agency having responsibility for the plan, that the approved plan has been so changed that it no longer complies with the provisions of section 1902 or that in the administration of the plan there is failure to comply substantially with any such provision. Until the Secretary is satisfied that there is no longer any failure to comply, he will make no further payments to the State or in his discretion will limit payments to categories under or parts of the plan not affected by such failure.

SECTION 1905. DEFINITIONS

Section 1905(a) defines the term "medical assistance" to mean 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 the recipient makes application) for individuals who are under the age of 21 and who except for section 406(a)(2) are (or would, if needy, be) dependent children as defined under title IV, or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 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) in-patient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) out-patient 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 age 21 or over and dental services for individuals under age 21;

(5) physicians' services, whether furnished in the office, the patient's home, a hospital, 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) skilled nursing home services and dental services for other individuals;

(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) in-patient hospital services and skilled nursing home services 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;

but the term does not include—

(A) payments with respect to care or services for an individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) 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 of mental diseases.

Section 1905(b) defines the term "Federal medical assistance percentage." Such percentage for a State is 100 percent minus the percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the 50 States and the District of Columbia. Such percentage is in no case less than 50 percent or more than 83 percent, except that for Puerto Rico, the Virgin Islands, and Guam it is set at 55 percent. Determination and promulgation by the Secretary of

the Federal medical assistance percentage will be in accordance with the provisions of section 1101(a)(8)(B) of the act, except that such promulgation will be made as soon as possible after enactment of the bill and it will be conclusive for each of the 6 quarters in the period January 1, 1966, through June 30, 1967.

Section 121(b) of the bill provides that no payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act for 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 (as added to such act by sec. 121(a) of the bill), or for any period thereafter.

Paragraph (1) of section 121(c) of the bill (effective January 1, 1966) amends section 1101(a)(1) of the act to make a necessary conforming change.

Paragraph (2) of section 121(c) of the bill amends section 1109 of the act to provide that any amount which is disregarded (or set aside for future needs) in determining eligibility of and amount of the aid or assistance for an individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX of the act is not to 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.

Paragraph (3) of section 121(c) of the bill (effective January 1, 1966) amends section 1115 of the act to make necessary conforming changes.

SECTION 122. PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

Section 122 of the bill amends sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act to authorize Federal financial participation in expenditures by a State under its approved plans under the respective public assistance titles of such act for premiums paid for supplementary medical insurance benefits for the aged (the insurance program under part B of title XVIII of the Social Security Act, as added by the bill) for individuals who receive money payments under any such title.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

PART 1—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SECTION 201. INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

Section 201(a) of the bill amends section 501 of the Social Security Act to increase the authorization of appropriations for grants to the States for maternal and child health services under part 1 of title V of such act to $45 million for the fiscal year ending June 30, 1966; $50 million for the fiscal year ending June 30, 1967; $55 million each for the fiscal years ending June 30, 1968 and 1969; and $60 million for the fiscal year ending June 30, 1970, and for each fiscal year there-

after. Under existing law the authorized appropriation is $40 million each for the fiscal years ending June 30, 1966 and 1967, $45 million each for the fiscal years ending June 30, 1968 and 1969, and $50 million for the fiscal year ending June 30, 1970, and for each year thereafter.

Section 201(b) of the bill amends section 504 of the act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon 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 to children in all parts of the State by July 1, 1975.

SECTION 202. INCREASE IN CRIPPLED CHILDREN'S SERVICES

Section 202(a) of the bill amends section 511 of the Social Security Act to increase the authorization of appropriations for grants to the States for crippled children's services under part 2 of title V of such act to $45 million for the fiscal year ending June 30, 1966; $50 million for the fiscal year ending June 30, 1967; $55 million each for the fiscal years ending June 30, 1968 and 1969; and $60 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter. Under existing law the authorized appropriation is $40 million each for the fiscal years ending June 30, 1966 and 1967, $45 million for the fiscal years ending June 30, 1968 and 1969, and $50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Section 202(b) of the bill amends section 514 of the act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon 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 to children in all parts o the State by July 1, 1975.

SECTION 203. TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

Section 203 of the bill amends part 2 of title V of the Social Security Act by adding a new section 516 which authorizes grants to public or other nonprofit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps. Authorizations for appropriations are $5 million for the fiscal year ending June 30, 1967, $10 million for the fiscal year ending June 30, 1968, and $17.5 million for each fiscal year thereafter.

SECTION 204. PAYMENT FOR INPATIENT HOSPITAL SERVICES

Section 204(a) of the bill amends section 503(a) of the Social Security Act to require a State plan for maternal and child health services to provide, effective July 1, 1967, 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.

Section 204(b) of the bill amends section 513(a) of the act to require a State plan for services for crippled children to provide, effective July 1, 1967, 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.

SECTION 205. SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Section 205 of the bill amends part 4 of title V of the Social Security Act by inserting a new section to provide special project grants to promote the health of school and preschool children. In conforming changes the heading of part 4 is revised accordingly and section 532 is redesignated section 533.

The new section 532(a) authorizes appropriations of $15 million for the fiscal year ending June 30, 1966, $35 million for the fiscal year ending June 30, 1967, $45 million for the fiscal year ending June 30, 1968, $50 million for the fiscal year ending June 30, 1969, and $55 million for the fiscal year ending June 30, 1970, for special project grants in order to promote the health of children and youth of school and preschool age, particularly in areas with concentrations of low-income families. Section 532(b) authorizes the Secretary to make grants to a State health agency and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency administering or supervising the administration of the crippled children's program under part 2q title V of the Social Security Act, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). Projects for children and youth of school age must include such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary. Treatment, correction of defects, and aftercare are to be available under the projects only to children who would not otherwise receive them because they are from low-income families or for other reasons beyond their control. Projects must provide for coordination of the health care and services provided under them with, and for utilization of, other State or local health, welfare, and education programs for children, and for payment of the reasonable cost of inpatient hospital services.

Section 532(c) authorizes the Secretary to make grants to a State health, mental health, or public welfare agency, and with the consent of the appropriate State agency to the health, mental health, or public welfare agency of any political subdivision of the State and to any public or nonprofit private agency or institution to pay not to exceed 75 percent of the cost of projects providing for the identification, with a view to providing as early as possible, care and treatment of children who are or are in danger of becoming emotionally disturbed, including the followup of children receiving such care or treatment. Projects

must provide for coordination of the care and treatment provided under it with, and utilization (to the extent feasible) of community mental health centers and other State or local agencies engaged in health, welfare, or education programs or activities for such children.

The new section 532(d) provides for payment of the grants under section 532 in advance or by way of reimbursement, in such installments and on such conditions as the Secretary determines.

SECTION 206. EVALUATION AND REPORT

Section 206 of the bill requires the Secretary to submit to the President for transmission to the Congress before July 1, 1969, a full report of the administration of section 532 of the Social Security Act (special project grants for health of school and preschool children) together with an evaluation of the program and recommendations as to continuation of and modifications in the program.

SECTION 207. INCREASE IN CHILD WELFARE SERVICES

Section 207 amends section 521 of the Social Security Act to increase the authorization of appropriations for grants to the States for child welfare services under part 3 of title V of such act to $45 million for the fiscal year ending June 30, 1966, $50 million for the fiscal year ending June 30, 1967, $55 million each for the fiscal years ending June 30, 1968 and 1969, and $60 million for the fiscal year ending June 30, 1970, and for each year thereafter.

SECTION 208. DAY CARE SERVICES

Section 208(a) amends title V, part 3 of the Social Security Act by striking out section 527.

Section 208(b) amends section 522 of the Social Security Act to provide that the Secretary shall allot to each State for use by the cooperating State public welfare agency which has a plan developed jointly by the State agency and the Secretary $70,000 and an amount which bears the same ratio to the remainder of the sum so appropriated as the product of (1) the population of the State under 21 and (2) the allotment percentage of the State (as determined under sec. 524) bears to the sum of the corresponding products of all the States.

Section 208(c) amends subparagraph B, section 523(a)(1) of the Social Security Act by adding a new clause (V) providing that day care under the plan will be provided only in facilities (including private homes) which are licensed by the State or approved as meeting the standards established for licensing by the responsible State agency.

Section 208(d) provides that the amendments made by section 208 apply to appropriations for the fiscal years beginning after June 30, 1965, and inserts the word "each" after $60 million in section 201(a) which amends the first sentence of section 501 of the Social Security Act and after $60 million in section 202(a) which amends the first sentence of section 511 of the Social Security Act.

PART 2. IMPLEMENTATION OF MENTAL RETARDATION PLANNING

SECTION 211. AUTHORIZATION OF APPROPRIATIONS

Section 211(a) of the bill amends section 1701 of the Social Security Act to authorize appropriations for assisting States in initiating the implementation and carrying out of planning and other steps to combat mental retardation. The amounts authorized to be appropriated are $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

Section 211(b) of the bill amends section 1702 of the act to provide that the sums appropriated pursuant to section 1701 for the fiscal year ending June 30, 1966, are to be available for grants during that fiscal year and the two immediately succeeding fiscal years, and that the sums appropriated for the fiscal year ending June 30, 1967, are to be available for such grants during that fiscal year and the immediately succeeding fiscal year.

PART 3—PUBLIC ASSISTANCE AMENDMENTS RELATING TO HEALTH CARE

SECTION 221. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASE

Paragraphs (1) and (2) of section 221(a) of the bill, and paragraphs (1) and (2) of section 221(d), amend the definitions of the terms "old-age assistance," "aid to the aged, blind, or disabled" (insofar as it relates to the aged), and "medical assistance for the aged," as those terms appear in titles I and XVI of the Social Security Act. These amendments remove the limitations on Federal participation in aid or assistance to aged individuals who are patients in institutions for tuberculosis or mental diseases or who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis.

Section 221 (b) and (c) of the bill, and paragraph (1) of section 221(d), amend the definitions of the terms "aid to the blind," "aid to the permanently and totally disabled," and "aid to the aged, blind, or disabled" (insofar as it relates to the blind or disabled), as those terms appear in titles X, XIV and XVI, respectively, of the Social Security Act so as to remove the existing limitations in those titles on Federal sharing in aid to individuals who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis. Federal financial participation would remain unavailable with respect to payments to or care in behalf of blind or disabled individuals who are patients in an institution for tuberculosis or mental diseases under such titles X and XIV, and under such title XVI in the case of individuals under age 65.

Paragraph (3) of section 221(a) of the bill, and paragraph (3) of section 221(d), amend sections 2(a) and 1602(a), respectively, of the Social Security Act to add new plan requirements for a State which elects to include assistance in its State plan under title I (or aid or assistance in its State plan under title XVI, insofar as such aid relates

to the aged) to or in behalf of individuals who are patients in mental institutions. Such plan requirements are the same as those set forth in section 1902(a) (20) and (21) of title XIX as added to the Social Security Act by section 121(a) of the bill.

Paragraph (4) of section 221(a) of the bill, and paragraph (4) of section 221(d), add provisions to sections 3 and 1603, respectively, of the Social Security Act comparable to the provision set forth in section 1903(b) of title XIX (as added by sec. 121(a) of the bill). These provisions make the Federal share in State expenditures with respect to aged patients in institutions for mental diseases contingent upon a comparable increase in total expenditures in the State for mental health services.

Section 221(e) of the bill provides that the amendments made by the preceding provisions of section 221 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

SECTION 222. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

Sections 222(a) and 222(b) of the bill amend sections 6(b) and 1605(b), respectively, of the Social Security Act, to permit Federal sharing in State expenditures for medical assistance for the aged in the case of individuals who also received old-age assistance or aid to the aged, blind, or disabled in the month of their admittance to or discharge from a medical institution.

Section 222(c) of the bill provides that these amendments will apply to expenditures under a State plan approved under title I or XVI of the act with respect to care and services provided under such plan after June 1965.

PART 4—MISCELLANEOUS AMENDMENTS RELATING TO HEALTH CARE

SECTION 231. HEALTH STUDY OF RESOURCES RELATING TO CHILDREN'S EMOTIONAL ILLNESS

Section 231(a) authorizes the Secretary, upon the recommendation of the National Advisory Mental Health Council and after securing the advice of experts in pediatrics and child welfare, to make grants for research into and study of resources, methods and practices for diagnosing or preventing mental illness in children and of treating, caring for, and rehabilitating children with emotional illness.

Section 231(b) provides that grants may be made to one or more organizations on condition that such organizations agree to undertake and conduct a coordinated program of research into and study of all aspects of the resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illness.

Section 231(c) defines organization as a nongovernmental agency, organization, or commission, composed of representatives of leading national medical, welfare, educational, and other professional associations, organizations, or agencies active in the field of mental health of children.

Section 231(d) authorizes an appropriation of $500,000 each year for the fiscal years ending June 30, 1966, and June 30, 1967 for the grants authorized by section 231(a); provides that the terms of the grant stipulate that the research be completed no later than 2 years after it is inaugurated and for the filing of annual grant reports.

TITLE III—SOCIAL SECURITY AMENDMENTS

Section 300 of the bill provides that title III of the bill may be cited as the "Old-Age, Survivors, and Disability Insurance Amendments of 1965."

SECTION 301. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 301 of the bill provides for a revised benefit table to effectuate a 7-percent benefit increase and new maximum benefit amounts.

Primary insurance amount

Section 301(a) of the bill amends section 215 of the Social Security Act to substitute for the present benefit table a new table. The new table effectuates the increase for people who were on the benefit rolls in any month after December 1964 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in and after the month in which the bill is enacted. The new primary insurance amounts, shown in column IV of the table, represent an increase of 7 percent over the primary insurance amounts provided in present law for average monthly wages of $400 or less with a minimum increase of $4. (The primary insurance amount is the amount payable to a worker who retires at or after age 65 or to a disabled worker, and it is also the amount from which all other benefits are determined.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 62.97 percent of the first $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150. Benefits in the present table approximate 58.85 percent of the first $110 of average wage plus 21.4 percent of the next $290.

The primary insurance amounts provided by the revised table range from a minimum of $44 for people whose average monthly wage is $67 or less to a maximum of $168 for people who have the average monthly wage of $550 that will become possible in the future with the $6,600 contribution and benefit base which the bill (in sec. 320) provides. The primary insurance amounts of retired workers who are now on the benefit rolls are raised from $40 to $44 at the minimum and from $127 to $135.90 at the maximum.

Under the revised benefit table, the total monthly amount of benefits payable to a family on the basis of a single earnings record will be determined on the basis of a new formula. The maximum family benefit in present law (shown in col. V of the benefit table) is the smaller of 80 percent of the average monthly wage or $254—twice the maximum primary insurance amount of $127—but it does not operate to reduce the family benefits to less than 1½ times the primary insurance amount. The $254 amount applies over a rather wide range of

average monthly wage levels, so that the maximum family benefit is not wage-related at average monthly wage levels above $317. The formula used to determine the new maximum family benefit amounts (these amounts are shown in col. V of the benefit table in the bill) is 80 percent of the average monthly wage up to the point at which the average monthly wage amount is two-thirds of the maximum possible average monthly wage specified in the law, plus 40 percent of the remainder of the average monthly wage. This formula produces, at the maximum average monthly wage, a maximum family benefit of two-thirds of the average monthly wage. Specifically, with the $6,600 contribution and benefit base, the 40-percent part of the formula would begin to operate above the $370 average monthly wage level, which is about two-thirds of the maximum average monthly wage of $550 (more precisely, it is the top of the average monthly wage bracket that includes the amount that is two-thirds of $550). As under present law, the maximum will not operate to reduce family benefits below 1½ times the primary insurance amount. Under the bill, the maximum amount of monthly benefits payable to a family would range from a minimum of $66 to a maximum of $368.

Primary insurance amount under 1958 act, as modified

Section 301(b) of the bill amends section 215(c) of the act to provide that a person who became entitled to old-age or disability insurance benefits before the date of enactment of the bill, or who died before such date, will have his primary insurance amount, as determined under the provisions of present law and appearing in column II of the revised table, converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II shows the primary amounts in effect prior to the Social Security Amendments of 1958 and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Maximum benefits for people already on the rolls

Section 301(c) of the bill amends section 203(a)(2) of the act to assure an increase in the family benefits for families who were on the benefit rolls after December 1964 and whose benefits were determined under the provisions of the law in effect prior to the enactment of the bill. In the absence of such a provision some families now on the benefit rolls could receive little or no increase in benefits, since their benefits are already at or near the maximum amount that would be payable to the family. The bill provides that the maximum family benefit for each month after December 1964 will be the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all family members' benefits after each such benefit has been increased by 7 percent (and rounded to the next higher 10 cents if it is not already a multiple of 10 cents). The section also repeals section 203(a)(3) of the act, which is a special saving clause for the maximum family benefits of people who became disabled before 1959. This clause is no longer needed since families whose benefits were determined under this clause are now covered by paragraph (2) of section 203(a) as amended by the bill.

Effective date

Section 301(d) of the bill provides that the benefit increases provided for by subsections (a), (b), and (c) of section 301 will be effective

for monthly benefits for months after December 1964 and for lump-sum death payments where death occurs in or after the month of enactment of the bill.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 301(e) of the bill is a special transitional provision which applies to an individual who was entitled to a disability insurance benefit for December 1964 and who became entitled to old-age insurance benefits in January 1965, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of present law, that would apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before he becomes entitled to an old-age insurance benefit will have as his primary insurance amount (and therefore his old-age insurance benefit) the amount in column IV of the table that is equal to his disability insurance benefit. In the situation outlined above, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table, which contains the new benefit amounts; and thus the general rule cannot be applied to this individual. Therefore, section 301(e) of the bill provides that his primary insurance amount is the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (This primary insurance amount in col. II is equal to his disability insurance benefit under present law.)

SECTION 302. COMPUTATION AND RECOMPUTATION OF BENEFITS

Section 302 of the bill provides for automatic recomputation of benefit amounts under title II of the Social Security Act to take account of earnings after entitlement to benefits, and makes technical changes in the provisions for computation of benefits to facilitate automatic recomputation.

Average monthly wage

Section 302(a)(1) of the bill amends subparagraph (C) of section 215(b)(2) of the act to exclude from an insured individual's computation base years (from which the years to be used in the benefit computation are chosen) the year in which he became entitled to benefits and to include in his computation base years (for purposes of survivors' benefits) the year in which he died. As a result of this change, an individual's computation base years are the calendar years occurring after 1950 (or after 1936, as provided in section 215 (d)) and up to the year in which his first month of entitlement to a benefit occurs or the year after the year in which he dies.

Section 302(a)(2) amends section 215(b)(3) of the act to provide that the number of an individual's elapsed years (which determine the number of years to be used in the benefit computation) will be counted up to the year in which he reaches age 65 (age 62 for women) or dies whether or not he is fully insured in that year. Under present law, an individual's elapsed years are counted up to the year in which he is *both* fully insured and age 65 (62 for women). Since almost all in-

sured individuals are now insured by the time they reach the required age, the deletion of the provision in present law results in a simplification of the computation provisions.

Section 302(a)(3) amends paragraphs (4) and (5) of section 215(b) of the act. Paragraph (4), as amended, makes the new provisions of section 215(b) applicable only in the case of an individual who dies or becomes entitled to benefits or to a benefit recomputation under section 215(f)(2), as amended by the bill, after December 1965. The requirement in present law that an individual have not less than six quarters of coverage after 1950 in order to have his average monthly wage determined entirely on his earnings after 1950 is omitted from the amended paragraph. Paragraph (5), as amended, preserves the present method of computing the average monthly wage for people who, after the bill is enacted and prior to 1966 (the effective date of automatic recomputation), become entitled to benefits or a recomputation of benefits.

Primary insurance benefit under 1939 act

Section 302(b) of the bill makes a minor conforming change and updates a reference in section 215(d) of the act, relating to computation of primary insurance benefits under the 1939 Social Security Act.

Certain wages and self-employment income not to be counted

Section 302(c) of the bill amends section 215(e) of the act by striking out paragraph (3), which provides for a recomputation, for self-employed people who operate on a fiscal-year basis, to include earnings in the year of entitlement that were not available for inclusion in the original computation. This provision will not be needed, since these earnings will be taken into account under the automatic recomputation provisions contained in section 215(f) as amended by the bill.

Recomputation of benefits

Section 302(d)(1) of the bill amends section 215(f)(2) of the act by providing for annual automatic recomputation of benefits, beginning in 1966.

The recomputation will take into account any earnings the person had in or after the year in which he became entitled to benefits (under present law, a recomputation to include earnings in a year after entitlement requires an application and is not available unless the person had earnings of more than $1,200 for the year). The bill would also delete the requirement in present law that the person have six quarters of coverage after 1950 in order to qualify for the recomputation. A recomputation under the amended section 215(f)(2) will be effective, in the case of a living beneficiary, with January of the year following the year in which the earnings were received, and in death cases it will be effective for survivors' benefits beginning with the month of death.

Section 302(d)(2) repeals paragraphs (3), (4), and (7) of section 215(f) of the act, thereby eliminating the provisions for a recomputation to include earnings in the year of entitlement to benefits or in the year in which an individual's benefits were recomputed on account of additional earnings, the provisions for a recomputation for the purpose of paying benefits to survivors of an individual who died after 1960 and who had been entitled to old-age insurance benefits, and the provision for recomputing at age 65 the benefits of an indi-

vidual who became entitled to benefits before that age. All of these are replaced by the automatic recomputation provision.

Computation of disability insurance benefits

Section 302(e) of the bill amends section 223(a)(2) of the act so that the provisions for computing disability insurance benefits will conform with the changed provisions for computing old-age insurance benefits.

Effective dates and saving provisions

Section 302(f)(1) of the bill provides that the repeal of section 215(e)(3) of the act made by section 302(c) (pertaining to recomputations for certain self-employed people) will be effective for individuals who become entitled to benefits after 1965.

Section 302(f)(2) provides that in any case where an individual would, by filing an application prior to January 2, 1966, be entitled to have his benefit recomputed under the provisions of existing law, the individual will be deemed to have filed an application on the date of enactment of the bill or the earliest date of eligibility thereafter and prior to January 2, 1966. Thus anyone who would profit from a recomputation under the provisions of present law will have his benefit amount recomputed automatically as though he had filed an application for that recomputation. The new automatic recomputation provisions will take over for the future.

Section 302(f)(3) retains paragraphs (3) and (4) of section 215(f) of present law for the purpose of providing, for survivors' benefits, a recomputation of the primary insurance amount of an individual who was entitled to an old-age insurance benefit and who died after 1960 and before 1966 without having filed an application for a recomputation. The new recomputation provisions will apply to deaths occurring after 1965.

Section 302(f)(4) retains until 1966 section 215(f)(7) of the act, which provides for the automatic recomputation of benefits to take account of earnings a man who is receiving actuarially reduced benefits may have had after entitlement and through the year of death or attainment of age 65. After 1965, these recomputations will be made under the new automatic recomputation provisions.

Section 302(f)(5) provides that the amendments made by section 302(e) (relating to computations of disability insurance benefits) will apply to individuals who become entitled to disability insurance benefits after 1965.

Section 302(f)(6) retains the provisions for figuring the average monthly wage which were in effect prior to the Social Security Amendments of 1960 so that an individual who was eligible for old-age insurance benefits before 1961 but who became entitled to benefits or died after 1960 can have his average monthly wage figured over less than 5 years of earnings where such a computation will result in a higher primary insurance amount. (Generally, under the Social Security Amendments of 1960, at least 5 years have to be used in the computation of the average monthly wage.)

Section 302(f)(7) repeals, effective January 2, 1966, an old provision in the 1954 amendments for a dropout recomputation based on the acquisition of six quarters of coverage after June 1953; this provision is no longer needed.

SECTION 303. DISABILITY INSURANCE BENEFITS

Under existing law, the term "disability" is defined as inability 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.

Paragraph (1) of section 303(a) amends clause (A) of the first sentence of section 216(i) of the Social Security Act by striking out the requirement that the individual's impairment be one that can be expected to be of long-continued and indefinite duration and substituting instead the requirement that the impairment be one that has lasted or can be expected to last for a continuous period of not less than 12 calendar months.

Paragraph (2) of section 303(a) amends paragraph (2) of section 223(c) to provide that the term "disability" means inability 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 which has lasted or can be expected to last for a continuous period of not less than 12 calendar months.

Paragraph (1) of section 303(b) of the bill amends (and recodifies) paragraph (2) of section 216(i) of the Social Security Act. It eliminates the present requirement that the individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end (as specified in this section) shall be accepted.

Paragraph (2) of section 303(b) of the bill makes conforming changes in section 216(i)(3) of the act.

Paragraph (3) of section 303(b) amends paragraph (1) of section 223(a) of the act to eliminate the requirement in present law that an individual must be under a disability when he files his application for disability insurance benefits in order to be eligible for such benefits. In view of the change in the definition of disability and the provision in present law granting 12 months retroactivity to applications, this amendment permits the payment of benefits in those cases of extended disability which terminated before an application was filed.

Paragraph (4) of section 303(b) of the bill amends section 223(c)(3)(A) of the act to eliminate the requirement that the individual must be under a disability which continues until his application for disability insurance benefits is filed. This amendment conforms to the amendment made by section 303(b)(3) of the bill, which eliminates the need for existence of disability at the time the application was filed.

Section 303(c) of the bill amends section 223(b) of the Social Security Act to take into account the amendment made by section 303(b)(3) of the bill.

Section 303(d) of the bill amends section 202(j)(1) of the act to make it clear that a disability benefit payable under section 223 will be reduced so as not to render erroneous benefits paid prior to the filing of an application for disability benefits. This is in conformity with the amendment made by section 304 of the bill under which a larger benefit can become payable for prior periods during which other benefits had already been paid.

Section 303(e) amends section 215(a)(4) of the act, which specifies, in the case of an individual entitled to a disability insurance benefit who dies or becomes entitled to an old-age insurance benefit, the method for determining the primary insurance amount on which survivors' benefits or old-age insurance benefits are based. The change adds an additional point—age 65—at which a woman's disability insurance benefit can be converted to a primary insurance amount. Under present law a disability insurance benefit is converted to a primary insurance amount at age 65 in the case of a man and at entitlement to an old-age insurance benefit in the case of a woman (which may occur at any time between ages 62 and 65 if her disability insurance benefit terminates). Since under the bill a worker can become entitled to a reduced disability insurance benefit at any time prior to age 65 when he was previously entitled to an old-age insurance benefit, this change is needed so that the primary insurance amount which determines the disability insurance benefit of a woman who was previously entitled to a reduced old-age insurance benefit can be retained as the primary insurance amount when she reaches age 65.

Paragraph (1) of section 303(f) of the bill provides that the amendments made by subsection (a), paragraphs (3) and (4) of subsection (b), subsections (c) and (d) of section 303 of the bill, and subparagraphs (B), and (E) of section 216(i)(2) of the Social Security Act (as amended by subsec. (b)(1) of sec. 303) will be effective with respect to applications under sections 223 and 216(i) of the Social Security Act filed in or after the month in which the bill is enacted, or with respect to applications filed before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been so given before such month but a civil action thereon is commenced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month. The provisions of the preceding sentence will also apply to applications for monthly insurance benefits under title II of the Social Security Act based on the wages or self-employment income of an applicant to whom (1) or (2) of the preceding sentence apply. However, no monthly insurance benefits under title II of the Social Security Act are to be payable or increased by reason of the amendments made by subsections (a) and (b) of section 303 of the bill for months before the second month after the month of enactment of the bill. Periods of disability as defined in section 216(i)(2) of the Social Security Act may be established on the basis of the modified definition of disability even though such periods commence before enactment of the bill.

Paragraph (2) of section 303(f) provides that section 215(a)(4) of the act as amended by subsection (e) of the bill, will be effective with respect to the primary insurance amounts of individuals who attain age 65 after the enactment of the bill.

SECTION 304. PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER ENTITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

Section 304 of the bill provides that an individual under age 65 may become entitled to disability insurance benefits after having become entitled to old-age, wife's, husband's, widow's, widower's, or parent's insurance benefits; this is not possible under existing law.

Section 304(a) adds a new paragraph (4) to section 202(k) of the Social Security Act to provide that a worker who is simultaneously entitled to an old-age insurance benefit and a disability insurance benefit for any month will get only one of the two benefits.

Section 304(b) changes the heading of section 202(q) of the act (relating to actuarial reduction of benefits) to include a reference to the reduction of disability insurance benefits and widow's insurance benefits (a reference to the latter is required because of the provision for payment of reduced benefits to widows at age 60 which is added to the act by sec. 307 of the bill).

Section 304(c) of the bill adds a new paragraph (2) to section 202(q) of the act and renumbers the present paragraphs (2) through (7) as paragraphs (3) through (8). The new paragraph (2) provides that if an individual is entitled to a disability insurance benefit after having been entitled to a reduced old-age insurance benefit, the disability insurance benefit (determined under sec. 223) will be reduced by the amount by which the old-age insurance benefit would have been reduced if the worker had reached age 65 in the month in which he most recently became entitled to the disability insurance benefit. For example, if a man became entitled at exact age 62 to a reduced old-age insurance benefit of $80 (based on a primary insurance amount of $100) and became entitled at exact age 63 to a disability insurance benefit of $105 (determined under sec. 223 of the act), the disability insurance benefit would be reduced by $6.60 (one-third of $20), the amount by which the old-age insurance benefit would have been reduced if the man had reached age 65 at the time when he became disabled. The effect of this provision is to reduce the disability insurance benefit to take account of the number of months for which the man actually got a reduced old-age insurance benefit before he became disabled.

Section 304(d) of the bill changes section 202(q)(3)(B) of the act (which provides for reducing wife's or husband's benefits where the wife or husband is also entitled to old-age benefits) to make the provisions of subparagraph (B) inapplicable for months for which the individual is entitled to a disability insurance benefit as well as a wife's or husband's benefit.

Section 304(e) amends subparagraph (C) of paragraph (3) (as redesignated by the bill) of section 202(q) of the act to provide that where a person is entitled to both a disability insurance benefit and to a reduced wife's, husband's, or widow's insurance benefit, the wife's, husband's, or widow's benefit will be reduced by the sum of: (1) the amount by which the disability insurance benefit was reduced to take account of prior entitlement to a reduced old-age insurance benefit, and (2) the amount by which the wife's, husband's, or widow's benefit would be reduced if it were equal to the amount by which such benefit (prior to any reduction) exceeded the unreduced disability insurance benefit.

Section 304(f) of the bill adds two new subparagraphs (F) and (G) to the redesignated paragraph (3) of section 202(q) of the act to provide for reducing the disability insurance benefit of an individual who becomes entitled to the disability benefit after having become entitled to a widow's benefit which is reduced because it was taken before age 62.

Subparagraph (F) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to that benefit *at or after attainment of age 62* and who is entitled for the same month to a reduced widow's benefit. The amount of the reduction in the disability insurance benefit is whichever of the following is larger: (1) the amount by which the disability insurance benefit had been reduced because of prior entitlement to a reduced old-age benefit at age 62 or later, or (2) a sum equal to the amount by which the widow's benefit which the woman was getting at age 62 was reduced plus the amount by which the disability insurance benefit would be reduced (because of prior entitlement to a reduced old-age insurance benefit) if the disability benefit were equal to the excess of the unreduced disability benefit over the unreduced widow's insurance benefit.

Subparagraph (G) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to the disability benefit *before attainment of age 62* and after entitlement to a reduced widow's benefit. Her disability insurance benefit will be reduced by the amount by which her widow's benefit would have been reduced if she had attained age 62 in the first month for which she became entitled to the disability insurance benefit.

Section 304(g) of the bill makes a conforming change in section 202(q)(4)(A) (as redesignated by the bill) to apply to a person who is entitled to a disability insurance benefit which is reduced because of prior entitlement to a reduced benefit the present provisions which set forth the method for reducing increases in benefits which occur after the person has come on the rolls and before he reaches age 65.

Section 304(h) of the bill adds a new subparagraph (F) to paragraph (7) (as redesignated by the bill) of section 202(q) of the act to provide that, in determining the "adjusted reduction period" (that is, the number of months in the reduction period for which a reduced benefit was actually paid and for which the old-age insurance benefit will be reduced for future months) applicable to a reduced old-age insurance benefit, any month for which a disability insurance benefit was payable will be excluded.

Section 304(i) of the bill is a conforming change in the redesignated paragraph (8) of section 202(q) to apply to the reduced disability insurance benefit the provision in existing law for reducing the amount of the reduction to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

Section 304(j) of the bill makes a technical conforming change in paragraph (2) of section 202(r) of the act (relating to the presumed filing of application by individuals eligible for old-age insurance benefits and for wife's or husband's insurance benefits).

Section 304(k) of the bill amends section 215(a)(4) of the act, which provides a method of determining the primary insurance amount of an individual entitled to a disability insurance benefit who dies or becomes entitled to an old-age insurance benefit (in the case of a woman) or attains age 65 (in the case of a man). Under existing

law the primary insurance amount in such cases is equal to the disability insurance benefit; this provision operates properly under existing law because the disability insurance benefit is never reduced and thus is always equal to the primary insurance amount. Under the bill, however, the disability insurance benefit may be reduced and therefore may be smaller than the primary insurance amount. Section 304(k) therefore provides that the primary insurance amount to be used in the case where a disability beneficiary dies or becomes entitled to old-age insurance benefits or attains age 65 shall be the primary insurance amount on which the disability insurance benefit was based rather than the amount of the disability insurance benefit itself.

Section 304(l) of the bill amends paragraph (2) of section 216(i) of the act to remove a reference to section 223(a)(3) which is repealed by section 304(n) of the bill.

Section 304(m) of the bill makes a conforming change in paragraph (2) of section 223(a) to take account of the reduction of the disability insurance benefit under the provisions of section 202(q) as amended by the bill.

Section 304(n) of the bill repeals paragraph (3) of section 223(a) of the act, thereby permitting an individual to become entitled to a disability insurance benefit after having become entitled to a widow's, widower's, parent's, old-age, wife's, or husband's insurance benefit.

Section 304(o) of the bill provides that the amendments made by section 304 are to apply with respect to monthly benefits for and after the second month following the month of enactment of the bill on the basis of applications in or after such month of enactment.

SECTION 305. DISABILITY INSURANCE TRUST FUND

Section 305(a) of the bill amends section 201(b)(1) of the Social Security Act to increase the percentage of taxable wages appropriated to the disability insurance trust fund (now one-half of 1 percent) to 0.70 of 1 percent, effective with respect to wages paid after 1965.

Section 305(b) of the bill amends section 201(b)(2) of the Social Security Act to increase the percentage of taxable self-employment income appropriated to the disability insurance trust fund (now three-eighths of 1 percent) to 0.525 of 1 percent, effective with respect to taxable years beginning after 1965.

SECTION 306. PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING SCHOOL AND IN CASE OF CHILD BECOMING DISABLED

Section 306(a) of the bill amends subparagraph (B) of section 202(d)(1) of the Social Security Act to provide for the payment of child's benefits to an individual up to the age of 22 if he is attending school and to an individual who is over 18 and under a disability which began before he attained age 22 (under present law the disability must have begun before the child attained age 18). A child will be considered to be under a disability if the disability began before he attained the age of 22 and lasted, or could be expected to last, for a continuous period of at least 12 calendar months or to result in his death.

Subsection (b)(1) of section 306 amends the first sentence of section 202(d)(1) of the Social Security Act (relating to the termination of child's benefits) by adding five new subparagraphs.

The new subparagraphs (D) and (E) retain the provisions of existing law which terminate a child's benefit if he marries, dies, or is adopted (except for adoption by certain relatives) and provide in general for the termination of the child's benefits at age 18 if he is no longer attending school and is not under a disability.

Paragraphs (F), (G), and (H) provide in general for the termination of child's benefits when he is no longer a full-time student, ceases to be disabled, or attains age 22, whichever is earlier. The new subparagraph (F) provides that benefits for a child who is not disabled and who has attained age 18 will terminate with the last month in which he is a full-time student.

The new subparagraph (G) provides that benefits for a child who is not disabled will terminate with the month before the month in which he attains age 22. The new subparagraph (H) provides that if the child is disabled, his benefits will terminate with the second month following the month in which he ceases to be under a disability.

Subsection (b)(2) of section 306 repeals a sentence which is no longer needed because it has been incorporated in the changes made by subsection (b)(1).

Subsection (b)(3) of section 306 adds two new paragraphs, (7) and (8), to section 202(d) of the act. The new paragraph (7) permits a child whose benefits are terminated after he attains age 18 to become reentitled to child's insurance benefits, on filing a new application, if he becomes a full-time student before age 22 or becomes disabled before that age. Such reentitlement would end in accordance with the termination provisions contained in the new subparagraphs (D), (F), (G), and (H).

The new paragraph (8) defines "full-time student" and "educational institution." A full-time student is an individual who is in full-time attendance at an educational institution; whether or not the student was in full-time attendance is to be determined by the Secretary taking into account the standards and practices of the school involved. Specifically excluded from the definition of "full-time student" is a person who is paid by his employer while attending school at the request (or pursuant to a requirement) of his employer. Benefits are payable for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or if the person is in fact in full-time attendance immediately after the end of the period.

The definition of "educational institution" includes all public schools, colleges, and universities, and all private schools, colleges, and universities which are accredited by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer, by at least three accredited institutions on the same basis as if transferred from an accredited institution.

Subsection (c)(1) of section 306 of the bill adds a new subsection (s) to section 202 of the act. Paragraph (1) of the new subsection (s) prevents a wife, widow, or surviving divorced mother from getting

benefits if the only child in her care is getting benefits solely because he is a student.

Paragraphs (2) and (3) of the new subsection (s) amend the provisions of law which permit a person with a childhood disability to continue to get benefits when he marries another beneficiary, and which permit such a beneficiary to continue to get benefits when he marries a person with a childhood disability, so that benefits will not be terminated if the child was under a disability which began before he attained age 22, instead of age 18 as under present law, or had been under such a disability in the third month before the month in which such marriage occurred. The paragraphs also make the new provisions defining disability applicable to: (1) The dependency requirements in present law for husband's and widower's benefits; (2) the provisions of existing law for terminating the benefits of a beneficiary married to a male disability beneficiary when his benefits terminate because he is no longer disabled; (3) the provisions of present law that exempt a disabled adult child from having his benefits withheld on account of work; and (4) the provisions of present law under which a disabled adult child can, upon marriage, become entitled to wife's, widow's, husband's, or widower's benefits.

The new paragraph (3) also provides that the exemption in present law from the dependency requirements for husband's and widower's benefits shall apply to a person receiving child's benefits if the person is under a disability that began before he attained age 22.

Subsections (c)(2) through (c)(13) of section 306 make conforming changes to incorporate references to the new subsection (s).

Subsections (c)(14) and (c)(15) of section 306 provide that the provisions of existing law which relate to withholding of benefits payable to a person with a childhood disability while an investigation of whether his disability still exists is being made or when he refuses to accept vocational rehabilitation services will not apply with respect to children over 18 who are attending school.

Subsection (d) of section 306 provides that the amendments made by that section will be effective for January 1965 and months thereafter. Where a child was already on the rolls in the month in which the bill is enacted no application will be required. Where a child was not entitled to a child's insurance benefit in the month of enactment, the amendments made by section 306 will apply only on the basis of applications filed in or after the month of enactment. In the case of a disabled child who becomes entitled to benefits on the basis of the requirements for childhood disability benefits as revised by section 306, the effective date will be the second month after the month of enactment.

SECTION 307. REDUCED BENEFITS FOR WIDOWS AT AGE 60

Widow's insurance benefits payable beginning at age 60

Section 307(a)(1) of the bill amends section 202(e) of the Social Security Act to provide that a widow may become entitled at age 60 to benefits based on the earnings record of her deceased husband. Section 307(a)(2) of the bill, by providing for the application to the benefits of section 202(q), provides that the benefits payable to widows who claim them before age 62 will be reduced to take account of the

longer period over which they will be paid. Under existing law, unreduced benefits equal to 82½ percent of the deceased husband's primary insurance amount are payable to a widow at or after age 62.

Reduction factors

Section 307(b)(1) of the bill amends section 202(q)(1) of the Social Security Act, governing the reduction of benefits payable to beneficiaries who elect to start getting them prior to attainment of age 65, to provide that widow's insurance benefits to which a woman is entitled for a month before she is 62 are reduced by five-ninths of 1 percent for each month in the reduction period (the months prior to attainment of age 62 for which she is entitled to a widow's benefit) and that benefits to which she is entitled for the month in which she attains age 62 and months thereafter are reduced by the same percentage for each month in the adjusted reduction period (the months prior to attainment of age 62 for which the widow has actually been paid a benefit). This is the same factor as that which applies to an old-age benefit which is payable prior to attainment of age 65. Under the amendment, the benefits provided for a widow before age 62 may be reduced for as many as 24 months. The reduction for a widow claiming her benefit at exactly age 60 would be 13⅓ percent; her benefit would be reduced from the 82½ percent of her husband's primary insurance amount which would be payable to her at age 62 to 71½ percent of such primary insurance amount. For a widow who gets reduced benefits, the amount of the reduction in benefits would be adjusted at age 62 (as it is now adjusted at age 65 for old-age, wife's, or husband's benefits) to take account of any months in which no benefit was paid.

Entitlement to benefits on own earnings record

Paragraphs (2) and (3) of section 307(b) of the bill amend section 202(q)(3) of the act (as renumbered by the bill) to provide that where a widow is entitled to a disability insurance benefit based on her own earnings when she becomes entitled to a reduced widow's benefit, the reduction in the widow's benefit applies only to the excess of the widow's benefit over the benefit payable on her own earnings record. Similar provision is made under existing law for a person who is entitled simultaneously to a reduced old-age benefit and a wife's or husband's benefit; for example, where a wife is entitled to a benefit based on her own earnings for the month for which she first becomes entitled to a wife's benefit the reduction factor applies only to the amount by which the wife's benefit exceeds her own benefit.

Reduction in subsequent old-age insurance benefit

Section 307(b)(4) of the bill adds a new subparagraph (E) to section 202(q)(3) of the act (as renumbered) to provide a method for reducing the old-age insurance benefit of a widow who is entitled to reduced widow's benefits. The old-age benefit (whether the woman begins to get it before or after she reaches age 65) will be reduced to take account of the widow's benefits paid to her before age 62. The amount of the reduction in the old-age benefit is whichever of the following is larger: (1) the reduction which would have been made in the old-age benefit if no widow's benefit had been payable, or (2) the dollar amount of the reduction in the widow's benefit plus the amount resulting from applying to the amount by which the

unreduced old-age benefit exceeds the unreduced widow's benefit the reduction factor which would have been applied to the unreduced old-age benefit if the woman had not been eligible for a reduced widow's benefit.

The operation of this provision may be illustrated by the following example: Assume that a woman upon reaching age 60 elects to start getting a widow's benefit and that the benefit is reduced from $50.40 (82½ percent of her husband's primary insurance amount) to $43.70—a $6.70 reduction (24 months times five-ninths of 1 percent, or 13⅓ percent of $50.40). Assume further that at age 64 she becomes entitled to an old-age benefit based on a primary insurance amount of $76. If no widow's benefit had been payable, the old-age benefit would have been $71—a $5 reduction (12 months times five-ninths of 1 percent, or 6⅔ percent of $76). Under the new section 202(q)(3)(E), the amount by which her unreduced old-age benefit exceeds her unreduced widow's benefit, or $25.60 (the $76 old-age benefit less the $50.40 widow's benefit), will be reduced to $23.90—a $1.70 reduction (6⅔ percent of $25.60). Since the sum of the amount of the reduction in her widow's benefit and the reduction in her excess old-age benefit—$8.40 ($6.70 plus $1.70)—is larger than the amount by which her old-age insurance benefit would have been reduced—$5—her old-age benefit must be reduced by the larger amount—$8.40—that is, from $76 to $67.60.

Reduction where widow has a child in her care

Section 307(b)(5) of the bill adds to section 202(q)(5) of the act (as renumbered) a new subparagraph, (D), to provide that, regardless of the provisions for reducing the benefits of widows who claim them before age 62, in no case will a widow who had in her care a child entitled to child's benefits get less in benefits for months in which she had the child in her care than the amount of the mother's insurance benefit (75 percent of her husband's primary insurance amount). This could happen, for example, where a widow started getting widow's benefits at age 60 (71½ percent of her husband's primary insurance amount) and starting at age 61 a child entitled to benefits was placed in her care. This provision permits her benefit amount for any month in which she has a child in her care to be increased to 75 percent of her husband's primary insurance amount.

Reduction period

Section 307(b)(6) of the bill amends section 202(q)(6) of the act (as renumbered) to provide that, in the case of widow's insurance benefits, the "reduction period" will begin with the first month for which the woman is entitled to a reduced widow's benefit and will end with the month before the month in which she attains age 62. The number of months in the "reduction period" is the number that is multiplied by five-ninths of 1 percent to determine the reduction in the benefits.

Adjusted reduction period

Section 307(b)(7) of the bill amends section 202(q)(7) of the act (as renumbered), which describes the months which will be eliminated from the "reduction period" in determining the "adjusted reduction period" for purposes of establishing the benefit amount payable for months beginning with the month after the reduction period, to

provide that, in determining a widow's adjusted reduction period at age 62, months in which her reduced widow's benefit was increased because she had in her care a child of her deceased husband entitled to child's insurance benefits, months in which her benefit was withheld because she had earnings from work, and months beginning with the month in which the widow's benefit was terminated through the month prior to the widow's attainment of age 62, will not be counted. For example, if a widow elects to start getting benefits upon reaching age 60 her benefit amount will be reduced by five-ninths of 1 percent for each of the 24 months in the reduction period; if, starting at age 61, a child entitled to a benefit is placed in the widow's care and remains in her care for 6 months, her benefit amount will be adjusted at age 62 and, for future months, will be reduced by five-ninths of 1 percent for each of the 18 months in the adjusted reduction period.

Definitions

Section 307(b)(8) of the bill adds a new paragraph (9) to section 202(q) of the act. The new paragraph defines "retirement age", for purposes of the actuarial reduction provisions, as age 65 for old-age, wife's or husband's insurance benefits and age 62 for widow's insurance benefits.

Effective date

Section 307(c) of the bill provides that reduced widow's insurance benefits will be payable beginning with the second month after the month of enactment of the bill on the basis of applications filed in or after the month of enactment.

SECTION 308. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

Section 308(a) of the bill amends section 202(b) (relating to the payment of wife's insurance benefits) of the Social Security Act to provide for the payment of wife's insurance benefits to a divorced wife who is not married and who met one of the following support requirements at the time her former husband became entitled to old-age or disability insurance benefits, or at the time his period of disability began: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him. The amended section 202(b) also provides that a wife's benefits will not terminate if she has attained age 62 and is divorced after having been married for 20 years (benefits for a wife under age 62 with a child in her care would terminate if she was divorced, regardless of how long she had been married, since benefits are not provided for a young divorced wife with a child in her care until after the former husband's death). The amended section 202(b) also adds to the present provisions for terminating wife's benefits a provision for terminating a divorced wife's benefit if she marries someone other than the worker on whose earnings her benefit is based. However, if a divorced wife married a person entitled to benefits as a widower, parent, or disabled child, her benefits (and her new husband's benefits) would not be terminated.

Section 308(b)(1) amends section 202(e) (relating to the payment of widow's insurance benefits) of such act to provide for the payment of

widow's insurance benefits to a widow or a surviving divorced wife (subject to a support requirement in the case of the surviving divorced wife) who is not married. Under this provision a woman who is not married at or after age 60 will have whatever rights to widow's insurance benefits she has ever had, regardless of intervening marriages. To qualify for widow's insurance benefits a surviving divorced wife would have to meet one of the following support requirements at the time her former husband died, at the time he became entitled to old-age or disability benefits, or at the beginning of a period of disability which ended with his death or entitlement to monthly benefits: (1) She was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him. However, if the surviving divorced wife had been getting wife's insurance benefits based on her former husband's earnings record in the month before he died she would not have to meet the support requirement.

Section 308(b)(2) repeals the provision of present law under which a widow can have her benefits reinstated if she marries a person who dies within 1 year and is not insured. This provision is no longer needed since under the bill widow's benefits are payable if the woman *is not married*, regardless of whether she had been remarried.

Section 308(b)(3) of the bill makes conforming changes in the provisions for paying widow's benefits to a surviving divorced wife so that she will have the same treatment that a widow has under existing law in the event that she marries another survivor beneficiary.

Section 308(c) amends section 216(d) of the Social Security Act to define "divorced wife", "surviving divorced wife", "surviving divorced mother", and "divorce". Paragraphs (1) and (2) of the new subsection (d) define "divorced wife" and "surviving divorced wife" as a woman divorced from an individual to whom she was married for a period of 20 years immediately before the divorce. The new paragraph (3) of section 216(d) substitutes the term "surviving divorced mother" for the term "former wife divorced" in the definition of the latter term as contained in existing law. Paragraph (4) defines "divorce" and "divorced" as meaning a divorce *a vinculo matrimonii*. Existing law uses the full term wherever divorce is mentioned.

Section 308(d)(1) of the bill deletes a reference to "divorced *a vinculo matrimonii*" which is no longer needed because of the definition of divorce included in the law by section 308(c) of the bill.

Section 308(d)(2) amends the provisions of the Social Security Act for continuing child's, widower's, and parent's benefits if the beneficiary marries a person getting dependents' or survivors' benefits so that such benefits will not terminate if the beneficiary marries a divorced wife getting wife's benefits. Section 308(d)(2) also has the effect of providing that a woman getting benefits as a divorced wife who marries an old-age or disability insurance beneficiary may become eligible for wife's or widow's benefits on the basis of her new husband's wages and self-employment income without regard to the 1-year duration-of-marriage requirement in present law. (Similar treatment is provided for individuals entitled to widow's benefits under existing law.)

Paragraphs (3), (4), and (5) of section 308(d) amend section 202(g) (relating to mother's insurance benefits). Under the amendment made

by paragraph (3), a woman could qualify for mother's insurance benefits if she is not married (rather than if she has not remarried—see discussion of the comparable provision applying to widow's insurance benefits under sec. 308(b)(1) of the bill). Under the amendment made by paragraph (4), the support requirement which must be met if a surviving divorced mother is to qualify for mother's insurance benefits is the same as the new support requirement provided for a "divorced wife" and a "surviving divorced wife."

Paragraph (5) would replace the present term "former wife divorced" with the term "surviving divorced mother" in section 202(g) of existing law (relating to mother's insurance benefits).

Paragraph (6) of section 308(d) amends section 203(a) (relating to maximum family benefits) to provide that the monthly benefits paid to a divorced wife or a surviving divorced wife will not be reduced because of the limit on total family benefits and will not be counted in figuring the total benefits payable to others on the basis of the wages or self-employment income of the same individual.

Paragraphs (7), (8), (9), (10), (11), (12), and (13) of section 308(d) make conforming changes in various sections of the Social Security Act.

Section 308(e) of the bill provides an effective date for the section. Wife's and widow's insurance benefits for a divorced wife and a surviving divorced wife will be payable beginning with the second month after the month of enactment of the bill, but, in the case of an individual who was not entitled to benefits in the month after the month of enactment, only on the basis of an application filed in or after the month of enactment.

SECTION 309. TRANSITIONAL INSURED STATUS

Section 309(a) of the bill adds a new section 227 at the end of title II of the Social Security Act (after the new sec. 226 added by sec. 101 of the bill) to provide a special insured status for certain individuals now in their seventies or over who are not eligible for benefits under the provisions of present law because they (or their husbands) do not have 6 quarters of coverage.

Subsection (a) of the new section 227 provides that anyone who attains age 72 before 1969 and does not meet the existing insured-status requirements of section 214(a) will nevertheless be insured if he has one quarter of coverage for each year elapsing after 1950 and before the year in which he attained retirement age (65 for men, 62 for women) and if he has not less than 3 quarters of coverage. These provisions will merge gradually into the fully insured status provisions of the present law, so that men who attained age 65 and women who attained age 62 after 1956 will have to meet the requirements of present law in order to qualify for benefits. The following table sets forth the quarter-of-coverage requirements under this provision and shows how these requirements merge with the minimum six quarters of coverage required under present law:

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

The benefit payable to a person who meets only the transitional requirement will be $35. The wife of such a person, if she attains age 72 before 1969, will be eligible at age 72 for a wife's benefit of $17.50.

Subsection (b) of the new section 227 provides benefits for a widow who reaches age 72 before 1969 and whose husband died before 1957 or reached age 65 before 1957 and died before the transitional provisions go into effect. Such a widow could qualify for widow's benefits of $35 a month if the man had three, four, or five quarters of coverage, as shown in the following table (which also shows the requirements of present law):

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required under the bill for a widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

Subsection (c) of the new section 227 provides that a widow whose husband dies after the transitional provisions go into effect can become entitled to widow's benefits of $35 a month if she reaches age 72 before 1969, if her husband reached age 65 before 1957, and if he was (or, upon filing an application prior to his death, would have been) entitled to benefits under the transitional provisions.

Section 309 (b) of the bill makes the transitional insured status provisions effective for monthly benefits beginning with the second month following the month of enactment of the bill on the basis of applications filed in or after the month of such enactment.

SECTION 310. INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM BENEFITS

Section 310(a)(1) of the bill amends paragraphs (1), (3), and (4)(B) of section 203(f) of the Social Security Act. Paragraph (1), as amended, would provide that a beneficiary will receive the full amount of his benefits, regardless of the amount of his annual earnings, for any month in which he does not earn wages of more than $150, instead of for any month in which he does not earn wages of more than $100, as under present law. Paragraph (3), as amended, would provide that a beneficiary will receive full benefits for a taxable year if his total earnings in the year do not exceed $150, rather than $100,

multiplied by the number of months in the year. Paragraph (4)(B), as amended, would provide that for purposes of the retirement test a beneficiary will be presumed to have earned more than $150, rather than $100, in a month until it is shown to the satisfaction of the Secretary that the beneficiary did not earn more than that amount.

Section 310(a)(2) of the bill further amends paragraph (3) of section 203(f) of the act by changing the provision in present law under which there is a $1 reduction in benefits for each $2 of the first $500 of earnings above $1,200 to provide instead for a $1 reduction in benefits for each $2 of the first $1,200 of earnings above $1,800. Benefits will continue to be reduced by $1 for each $1 of earnings above $3,000, as they are now for earnings above $1,700.

Section 310(a)(3) of the bill amends paragraph (1)(A) of section 203(h) of the act to require a beneficiary to report his earnings to the Secretary whenever his annual earnings exceed $150, rather than $100, times the number of months in his taxable year.

Section 310(b) of the bill provides that the changes made by subsection (a) of this section shall be effective for taxable years after 1965.

SECTION 311. COVERAGE FOR DOCTORS OF MEDICINE

Amendments to Title II of the Social Security Act

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" and thus from self-employment coverage under section 211(c)(5) of the Social Security Act. Section 311(a)(1) of the bill amends section 211(c)(5) of the act by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to extend social security coverage to net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member.

Section 311(a)(2) of the bill conforms the provisions of the last two sentences of section 211(c) of the act to the amendment made by section 311(a)(1) of the bill.

Removal of exclusion for interns in Federal hospitals

Section 210(a)(6)(C)(iv) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(a)(3) of the bill amends section 210(a)(6)(C)(iv) of the act so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment is to extend social security coverage to such individuals with respect to services performed by them as interns or residents-in-training in the employ of hospitals of the Federal Government.

Removal of exclusion for student interns

Section 210(a)(13) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services

performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(a)(4) of the bill amends section 210(a)(13) so as to remove this exclusion. The effect of this amendment is to extend social security coverage to such interns unless their services are excluded under provisions other than section 210(a)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 210(a)(8)(B) of the Social Security Act if coverage was effected under such certificate.

Amendments to the Internal Revenue Code of 1954

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" under section 1402(c)(5) of the Internal Revenue Code of 1954. Section 311(b)(1) of the bill amends section 1402(c)(5) of the code by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to subject the net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member to the self-employment tax.

Section 311(b)(2) of the bill conforms the provisions of the last two sentences of section 1402(c) of the code to the amendment made by section 311(b)(1).

Technical amendments

Section 311(b)(3) of the bill conforms the language of sections 1402(e)(1) and 1402(e)(2) of the code to the amendment made by section 311(b)(1).

Removal of exclusion for interns in Federal hospitals

Section 3121(b)(6)(C)(iv) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(b)(4) of the bill amends section 3121(b)(6)(C)(iv) of the code so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment is to make the remuneration of such individuals for services performed by them as such interns or residents-in-training in the employ of hospitals of the Federal Government subject to the Federal Insurance Contributions Act.

Removal of exclusion for student interns

Section 3121(b)(13) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year

course in a medical school chartered or approved pursuant to State law. Section 311(b)(5) of the bill amends section 3121(b)(13) so as to remove this exclusion. The effect of this amendment is to extend coverage under the Federal Insurance Contributions Act to such interns unless their services are excluded under provisions other than section 3121 (b)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 3121(b)(8)(B) of the code if coverage was effected under such certificate.

Effective Date

Section 311(c) of the bill provides that the amendments made by paragraphs (1) and (2) of section 311(a) and by paragraphs (1), (2), and (3) of section 311(b), relating to the self-employment coverage of doctors of medicine, are effective for taxable years ending on or after December 31, 1965. The amendments made by paragraphs (3) and (4) of section 311(a) and by paragraphs (4) and (5) of section 311(b), relating to social security coverage of interns and residents-in-training, are effective with respect to services performed after 1965.

SECTION 312. GROSS INCOME OF FARMERS

Increasing gross income taken into account for optional method of computing net earnings from farm self-employment; amendments to title II of the Social Security Act

Section 312(a) of the bill amends section 211(a) of the Social Security Act to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, base his self-employment coverage on two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may report $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(a) of the bill an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, base his self-employment coverage on two-thirds of his gross income from farming; if he has gross income of more than $2,400 and net earnings from self-employment of less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from self-employment as a farmer.

Same: Amendments to the Internal Revenue Code of 1954

Section 312(b) of the bill amends section 1402(a) of the Internal Revenue Code of 1954 to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may treat $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(b), an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if he has gross income from farming of more than $2,400 and his net earnings from self-employment as a farmer are less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from such self-employment.

Effective Date

Section 312(c) of the bill provides that the amendments made by sections 312(a) and 312(b) will apply with respect to taxable years beginning after December 31, 1965.

SECTION 313. COVERAGE OF TIPS

Section 313 of the bill provides for treating cash tips received by an employee in the course of his employment as income from self-employment for social security tax and benefit purposes. The provisions of this section have no application to amounts which under existing law constitute wages.

Amendment to Title II of the Social Security Act

Section 313(a) of the bill amends section 211(c) of the Social Security Act (defining "trade or business" when used with reference to self-employment income or net earnings from self-employment for social security benefit purposes) by adding a new sentence at the end of the section. The new sentence provides that paragraph (2) of the section (which in general excludes from the term "trade or business" the performance of service by an individual as an employee) shall not have the effect of excluding from "net earnings from self-employment" cash tips received by an employee, on his own behalf and not on behalf of another employee, in the course of service which constitutes "employment" for social security benefit purposes, except that tips which under present law constitute remuneration for employment will con-

continue to do so. The effect of this provision is to cover tips as self-employment income (except for those already covered as wages). With respect to tips so covered, only business expenses attributable to such tips are to be deducted from gross income in computing net income from self-employment.

Amendment to the Internal Revenue Code of 1954

Section 313(b) of the bill amends section 1402(c) of the Internal Revenue Code (defining "trade or business" when used with reference to self-employment income or net earnings from self-employment for social security tax purposes) by adding at the end of the section a new sentence which is comparable to the new sentence added to the Social Security Act by section 313(a).

Section 313(c) of the bill provides that the amendments made by section 313 of the bill will be effective with respect to taxable years beginning after 1965.

SECTION 314. INCLUSION OF ALASKA AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

Section 314 of the bill amends section 218(d)(6)(C) of the Social Security Act by adding Alaska to the list of States which are permitted to divide their retirement systems into two divisions for coverage purposes, one division consisting of those members desiring coverage under the act and the other consisting of those who do not, with all new members being covered on a compulsory basis.

SECTION 315. ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

Section 315 of the bill amends section 218(d)(6)(F) of the Social Security Act to grant an additional opportunity to obtain coverage to State and local employees (in a State permitted to use the divided retirement system procedure) who had not previously chosen coverage under the divided retirement system provisions. The present law allows such employees a further opportunity to elect coverage only if a modification providing for such election is mailed or otherwise delivered to the Secretary before 1963, or, if later, 2 years after the date on which coverage was approved for the group that originally elected coverage. Any coverage elected after the original division must begin on the same date as was provided when the group was originally covered. Section 315 extends the time in which such persons could elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage).

SECTION 316. EMPLOYEES OF NONPROFIT ORGANIZATIONS

Section 316 of the bill amends section 3121(k) of the Internal Revenue Code of 1954 and section 105(b) of the Social Security Amendments of 1960.

Period for which certificate shall apply

Section 316(a)(1) of the bill amends section 3121(k)(1)(B) of the code, which relates to the period for which certificates filed by certain religious, charitable, etc., organizations for the purpose of waiving exemption from tax under chapter 21 of such code become effective. Under present law, a certificate filed pursuant to section 3121(k) is effective for the period beginning with whichever of the following is designated by the organization:

(1) The first day of the calendar quarter in which the certificate is filed,

(2) The first day of the calendar quarter succeeding such quarter, or

(3) The first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, but such period may not begin earlier than the first day of the fourth calendar quarter preceding the quarter in which such certificate is filed.

This amendment removes the limition that the period may not begin earlier than the first day of the fourth calendar quarter preceding the quarter in which such certificate is filed (see par. (3) above) and provides, in lieu thereof, that the period may not begin earlier than the 1st day of the 20th calendar quarter preceding the quarter in which the certificate is filed.

Section 316(a)(2) provides that the amendment made by section 316(a)(1) will apply in the case of any certificate filed under section 3121(k)(1)(A) of the code after the date of enactment of the bill.

Amendment of certificate filed before 1966

Section 316(b) of the bill amends section 3121(k)(1) of the Internal Revenue Code of 1954 by adding a new subparagraph (H). Such subparagraph (H) provides that an organization which files a certificate pursuant to section 3121(k)(1) of the code before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the 20th calendar quarter preceding the quarter in which such certificate is so amended. Pursuant to the new subparagraph (H), an organization which has filed, prior to 1966, a waiver certificate (without regard to whether the certificate is filed before or after the enactment of the bill) may amend such certificate so as to make it effective with the first day of any calendar quarter preceding the first quarter for which the certificate is effective without amendment. However, such a certificate may not be made effective, through an amendment, for any calendar quarter which begins earlier than the 20th calendar quarter preceding the calendar quarter in which such organization files an amendment to its certificate. An amendment to a waiver certificate filed under subparagraph (H) by a nonprofit organization would be effective with

respect to the service of those employees who concurred in the filing of the original certificate and who concur in the filing of the amendment to such certificate. For purposes of computing interest and for purposes of section 6651 of the Internal Revenue Code of 1954 (relating to addition to tax for failure to file a tax return), the due date for the return and the payment of the tax for any calendar quarter resulting from the filing of such an amendment shall be the last day of the month following the calendar quarter in which the amendment is filed. The period for assessing taxes which become payable under the new subparagraph (H) would not expire before the expiration of 3 years from such due date.

Validation of certain remuneration erroneously reported as wages by nonprofit organizations

Section 316(c)(1) of the bill amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive social security credit for remuneration erroneously reported on his behalf by the organization in any taxable period from January 1, 1951, through June 30, 1960. Section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will (where the conditions prescribed by the amendment are met) permit the validation of erroneously reported wages of workers who cannot be covered through the filing of a waiver certificate by the organization because they are no longer in the employ of the organization when it files its certificate. Under section 105(b), as amended by the bill, remuneration paid to an individual for service before the calendar quarter in which the organization files its waiver certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 may be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, to the extent that an amount has been paid as social security taxes with respect to such remuneration on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization files its waiver certificate. This rule applies, however, only if the service would have constituted employment as defined in section 210 of the Social Security Act if the requirements of section 3121(k)(1) of the code were satisfied, and only if the following conditions are met:

(1) the person who performed the service (or a fiduciary acting for him or his estate, or a survivor of such individual who is or may become entitled to monthly benefits under title II of the Social Security Act on his earnings record) makes a request (in such form and manner, and with such official, as the Secretary of Health, Education, and Welfare may by regulations prescribe) that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act;

(2) a certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 is filed by the organization not later than the date on which the request for validation is made;

(3) the individual requesting the validation is no longer employed by the organization on the date the organization files its waiver certificate; and

(4) if any part of the amount paid as social security taxes as previously described with respect to such remuneration paid to an individual is credited or refunded, the amount credited or

refunded, plus any interest allowed, must be repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization files its waiver certificate. In addition, the so-called validation of wages is to be permitted only for remuneration received for service which is performed during the period for which an organization's waiver is effective. Thus, former employees of an organization which has made erroneous reports receive no greater retroactive social security coverage than employees who are employed by the organization on the date the organization files its waiver certificate and are covered only for the retroactive period for which the certificate is made effective.

Effective dates of validating provisions

Section 316(c)(2) of the bill provides that the provisions of section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will become effective upon enactment of the bill. The provisions of the existing section 105(b) of the Social Security Amendments of 1960 will continue to apply to requests for validation filed before enactment of the bill. The filing of a request by an individual for validation under the existing provisions of section 105(b) of the Social Security Amendments of 1960 does not bar him from filing another request for validation under section 105(b) as amended by the bill.

Section 316(d) of the bill permits the validation of erroneously reported wages paid to employees of a nonprofit organization which has filed a waiver certificate but which nevertheless failed to provide effective social security coverage for some of its employees. Under section 316(d), remuneration paid to an individual for service which is excluded from employment under title II of the Social Security Act, and which is performed during the period in which the organization had in effect a waiver certificate under section 3121(k)(1) of the Internal Revenue Code of 1954, may be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act if any amount has been paid as social security taxes with respect to such remuneration on or before the date of enactment of this act, if the service would have constituted employment as defined in section 210 of the Social Security Act if the requirements of section 3121(k)(1) of the code had been satisfied, and if the individual was listed at any time during the period the organization had a waiver certificate in effect under section 3121(k)(1) of the Internal Revenue Code as a concurring employee, or he filed a validation request under section 105(b) of the Social Security Amendments of 1960 as in effect prior to the enactment of this act (but such listing or validation request was not effective with respect to the service being validated by this subsection).

SECTION 317. COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT OF COLUMBIA

Sections 317(a) and 317(b) of the bill amend the Social Security Act (sec. 210(a)(7)) and the Internal Revenue Code of 1954 (sec. 3121(b)(7)) to include in the definition of employment services performed by certain temporary employees of the District of Columbia. Under the amendments, service performed in the employ of the District of Columbia, or any wholly owned instrumentality thereof, is

included as employment if such service is not covered by a retirement system established by a law of the United States, except that the extension of coverage is not to apply to service performed: (1) In a hospital or penal institution by a patient or inmate thereof, (2) in a hospital of the District of Columbia by student nurses and certain other student employees (other than as a medical or dental intern or as a medical or dental resident-in-training) included under section 2 of the act of August 4, 1947 (5 U.S.C. 1052), (3) on a temporary basis in certain emergencies, or (4) as a member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

Section 317(c) of the bill amends section 3125 of the Internal Revenue Code of 1954 (relating to returns in the case of governmental employees in Guam and American Samoa) by changing the heading thereof and adding a new subsection (c). The new subsection (c) provides that the return and payment of the employee and employer taxes imposed under chapter 21 of the code (Federal Insurance Contributions Act) with respect to services performed as employees of the District of Columbia, or of any wholly owned instrumentality of the District of Columbia, may be made by the Commissioners of the District of Columbia or by such agents as they may designate. A person making such return may, for convenience of administration, make payments of the employer tax imposed under section 3111 without regard to the dollar limitations in section 3121(a)(1)(although this subsection would not authorize such person to disregard these dollar limitations as to remuneration includible in returns made by him). The purpose is to relieve a person making a return on behalf of any department or agency of the District of Columbia or any instrumentality wholly owned thereby, of any necessity for ascertaining whether any wages have been reported for a particular employee by any other reporting unit of such government or instrumentality.

Section 317(d) of the bill amends section 6205(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section 3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6205(a) of the code, relating to adjustments of underpayments of such taxes. Thus, adjustments of underpayments will be made by the reporting unit by which the underpayment was made.

Section 317(e) of the bill amends section 6413(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section 3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6413(a) of the code, relating to adjustments of overpayments of such taxes. Thus, adjustments of overpayments will be made by the reporting unit by which the overpayment was made.

Section 317(f) of the bill amends paragraph (2) of section 6413(c) of the Internal Revenue Code of 1954 by redesignating the heading of

such paragraph (2) and by adding to such paragraph (2) a new subparagraph (F). The new subparagraph provides that for purposes of the special credit or refund provisions contained in section 6413(c)(1) of the code, the Commissioners of the District of Columbia and each agent designated by them to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act will be deemed to be a separate employer. The effect of this amendment is to permit a claim for special credit or refund, rather than a general claim for refund under section 6402(a), in any case where an employee receives more than the maximum creditable wages in a calendar year by reason of having performed services for two or more reporting units of the District of Columbia or any instrumentality wholly owned thereby.

Section 317(g) of the bill provides that the amendments made by section 317 will apply with respect to service performed after the calendar quarter in which such section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and pt. A of title XVIII) of the Social Security Act extended to the officers and employees coming under the provisions of such amendments.

SECTION 318. COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

Section 318 of the bill amends section 102(k) of the Social Security Amendments of 1960 by adding a new paragraph (2) permitting the coverage agreement with the State of California to be modified to apply to certain additional services performed for any hospital affected by any modification (in the California State coverage agreement) executed pursuant to section 102(k). The services which could thus be covered are those performed by individuals who were or are employed by such State (or any political subdivision thereof) after December 31, 1959, in any position described in section 102(k). The State will have until the end of the sixth month after the month of enactment in which to so modify its agreement. Such modification will be effective with respect to services performed on or after January 1, 1962; it will also be effective with respect to services performed before January 1, 1962, where contributions in the proper amount have been paid before the date of enactment of the bill.

SECTION 319. TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO INSURANCE

Amendment to the Internal Revenue Code of 1954

Section 319(a) of the bill amends section 1402(c) of the code by adding a new paragraph (6) which excepts from the term "trade or business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under the new subsection (h) (as added by sec. 319(c)) of section 1402 is effective with respect to them. The effect of the amendment is to exempt from the self-employment tax an individual who is granted an exemption under section 1402(h) of the code.

Amendment to title II of the Social Security Act

Section 319(b) of the bill amends section 211(c) of the Social Security Act by adding a new paragraph (6) which excepts from the term "trade or business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under new subsection (h) (as added by sec. 319(c)) of section 1402 of the Internal Revenue Code of 1954 is effective with respect to them. The effect of the amendment is to remove from social security coverage a self-employed individual who is granted an exemption from tax under section 1402(h) of the code.

Application for exemption from self-employment tax; amendment to the Internal Revenue Code

Section 319(c) of the bill amends section 1402 of the code by adding a new subsection (h).

Paragraph (1) of section 1402(h) provides that any individual may file an application (in such form and manner and with such official as may be prescribed by regulations under sec. 1402(h)) for an exemption from the tax imposed on self-employment income if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to the acceptance of the benefits of any private or public insurance making payments in the event of death, disability, old-age, or retirement or making payments toward the cost of, or providing services for, medical care. An individual who applies for exemption must, therefore, among other things, be opposed to all types of benefits or payments under titles II and XVIII of the Social Security Act.

In order that an individual may be granted an exemption from the tax imposed on self-employment income, subparagraph (A) of section 1402(h)(1) provides that the individual's application for exemption must contain, or be accompanied by, such evidence of such individual's membership in, and adherence to the tenets or teachings of, the religious sect or division thereof as the Secretary of the Treasury or his delegate may require for purposes of determining such individual's compliance with the requirements of the first sentence of paragraph (1) of section 1402(h), and subparagraph (B) of such section provides that such application must be accompanied by the individual's waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person.

In addition to the requirements of subparagraphs (A) and (B) relating to the individual who files application for exemption from the tax on self-employment income, subparagraphs (C), (D), and (E) of section 1402(h)(1) provide that an exemption may be granted only if the Secretary of Health, Education, and Welfare makes the following findings with respect to the religious sect or division thereof of which such individual is a member:

1. That the sect or division thereof has the established tenets or teachings by reason of which the individual applicant is conscientiously opposed to the benefits of certain types of insurance;
2. That it is the practice, and has been for a period of time

which the Secretary deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which, in the judgment of the Secretary, is reasonable in view of the general level of living of the members of the sect or division thereof;

3. That the sect or division thereof has been in existence continuously since December 31, 1950.

Section 1402(h)(1) of the code further provides that an exemption from the tax on self-employment income may not be granted to an individual if any benefit or other payment referred to in subparagraph (B) of such section became payable at or before the time of the filing of such waiver. This provision applies if any such benefit or other payment would have become payable at such time but for a reduction of or deduction from such benefit or payment in accordance with the provisions of section 203 (relating to reduction of insurance benefits) or 222(b) (relating to deduction on account of refusal to accept rehabilitation services) of the Social Security Act.

Paragraph (2) of section 1402(h) of the code provides rules relating to the time for filing the application for exemption described in section 1402(h)(1). Subparagraph (A) of section 1402(h)(2) provides that an individual who has self-employment income (determined without regard to the exception contained in sec. 1402(c)(6)) for any taxable year beginning after December 31, 1950 (see sec. 319(e) of the bill, relating to effective date), and ending before December 31, 1965, must file his application for exemption on or before April 15, 1966. Subparagraph (B) of section 1402(h)(2) provides that in any other case an individual must file his application for exemption on or before the due date of the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, in which he has self-employment income (determined without regard to sec. 1402(c)(6)). If an individual fails to file an application for exemption from the self-employment tax within the time prescribed by section 1402(h)(2) (A) or (B), whichever is applicable in his case, he will not be entitled to the exemption.

Paragraph (3) of section 1402(h) provides that an exemption granted to an individual pursuant to section 1402(h) will apply with respect to all taxable years beginning after December 31, 1950. However, subparagraph (A) of section 1402(h)(3) provides that such exemption will not apply for any taxable year which begins before the taxable year in which the individual who files an application for exemption first became a member of a recognized religious sect or division thereof and was an adherent of established tenets or teachings of such sect or division by reason of which he was conscientiously opposed to the acceptance of the benefits of certain types of insurance. Subparagraph (A) further provides that such exemption will not apply for any taxable year which begins before the date as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member had the established tenets or teachings referred to in section 1402(h)(1), and that it was the practice of such sect or division to make reasonable provision for its dependent members. Subparagraph (B) of section 1402(h)(3) provides that an exemption granted pursuant to section 1402(h) will cease to be effective for any taxable year ending after the time the individual who files an application for exemption ceases to meet the

requirements of the first sentence of section 1402(h)(1), or after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member ceases to have the required tenets or teachings or ceases to make reasonable provision for its dependent members.

Paragraph (4) of section 1402(h) provides that in any case where an individual who has self-employment income dies before the expiration of the time prescribed in section 1402(h)(2) for filing an application for exemption pursuant to section 1402(h), such an application may be filed with respect to such deceased individual within the time prescribed in section 1402(h)(2) with respect to him by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of sec. 205(c)(1)(C) of the Social Security Act).

Waiver of benefits; amendment to title II of the Social Security Act

Section 319(d) of the bill adds a new subsection (v) to section 202 of the Social Security Act. If an individual is granted a tax exemption under section 1402(h) of the Internal Revenue Code of 1954, no benefits or other payments are to be payable to him under title II of the Social Security Act, no payments are to be made on his behalf under part A of title XVIII (hospital insurance benefits for the aged), and no benefits or other payments are to be payable to him on the basis of the wages and self-employment income of any other person, after the filing of his waiver of benefits pursuant to section 1402(h) of the code. If the tax exemption ceases to be applicable, the waiver is to cease to be applicable to the extent benefits or other payments are based (1) on his self-employment income for and after the first taxable year for which the waiver ceases to be effective, and (2) on his wages for and after the calendar year which begins with or in such taxable year.

Effective date

Section 319(e) of the bill provides that the amendments made by section 319 will apply with respect to taxable years beginning after December 31, 1950. Section 319(e) of the bill also provides, for purposes of such effective date, that chapter 2 of the Internal Revenue Code of 1954 (secs. 1401 through 1403) shall be treated as applying to all taxable years beginning after December 31, 1950. Thus, an application for exemption from tax under section 1402(h) of the Internal Revenue Code of 1954 will be treated as an application for exemption from the tax on self-employment income imposed by the Internal Revenue Code of 1939.

Refund or credit of taxes

Section 319(f) of the bill provides that if refund or credit of any overpayment resulting from the enactment of such section 319 is prevented, by the operation of any law or rule of law, on the date of enactment of the bill or at any time on or before April 15, 1966, refund or credit of such overpayment may, nevertheless, be made or allowed if claim therefor is filed on or before April 15, 1966. Section 319(f) further provides that no interest is to be allowed or paid on any overpayment resulting from the enactment of section 319.

SECTION 320. INCREASE IN EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 320 of the bill raises the maximum amount of annual earnings subject to social security tax and counted toward benefits (the contribution and benefit base) from $4,800 to $6,600 beginning with 1966.

Amendments to Title II of the Social Security Act

Definition of wages

Section 320(a)(1) of the bill amends section 209(a) of the Social Security Act (defining wages) to make the $6,600 contribution and benefit base applicable to wages paid after 1965.

Definition of self-employment income

Section 320(a)(2) amends section 211(b)(1) of the act (defining self-employment income) to make the $6,600 contribution and benefit base applicable for taxable years ending after 1965.

Quarter of coverage

Section 320(a)(3) amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining quarter of coverage) to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1965 if his wages for such year equal $6,600 (rather than $4,800 as in present law). An individual will also be credited with a quarter of coverage for each quarter of a taxable year ending after 1965 in which the sum of his wages and self-employment income equals $6,600 (rather than $4,800).

Average monthly wage

Section 320(a)(4) amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing an individual's average monthly wage) so as to increase from $4,800 to $6,600, effective for calendar years after 1965, the maximum amount of annual earnings that may be counted in the computation of an individual's average monthly wage for purposes of determining benefit amounts.

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 320(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining self-employment income) by increasing the maximum annual limitation on self-employment income subject to the self-employment tax from $4,800 to $6,600 for taxable years ending after 1965.

Definition of wages

Section 320(b)(2) amends section 3121(a)(1) of the code (defining wages) by increasing the maximum annual limitation on wages subject to social security tax from $4,800 to $6,600 for calendar years after 1965.

Federal service

Section 320(b)(3) amends section 3122 of the code (relating to Federal service) so as to conform its provisions to the changes made in increasing the contribution and benefit base from $4,800 to $6,600 for calendar years after 1965.

Returns in the case of governmental employees in Guam and American Samoa

Section 320(b)(4) amends section 3125 of the code (relating to governmental employees in Guam and American Samoa) so as to conform its provisions to the $6,600 contribution and benefit base for calendar years after 1965. (This increase in the base will also apply to the temporary employees of the District of Columbia who are included in section 3125 by section 317(c) of the bill.)

Special refunds of employee tax

Sections 320(b)(5) and 320(b)(6) amend section 6413(c) of the code (relating to special refunds of social security tax paid by an employee on aggregate wages in excess of $4,800 received by him from more than one employer during a calendar year) so as to conform the special refund provisions to the $6,600 contribution and benefit base for calendar years after 1965.

Effective Date

Section 320(c) provides effective dates for the changes made by the section. The amendments made by section 320 (a)(1) and (a)(3)(A) and by section 320(b) (except par. (1)) are applicable only with respect to remuneration paid after December 1965; the amendments made by section 320 (a)(2), (a)(3)(B), and (b)(1) are applicable only with respect to taxable years ending after 1965; and the amendments made by section 320(a)(4) are applicable only with respect to calendar years after 1965.

SECTION 321. CHANGES IN TAX SCHEDULES

Section 321 of the bill provides new schedules of social security tax rates, with the rates provided for hospital insurance being set forth in schedules which are separate from those provided for old-age, survivors, and disability insurance.

Self-employment tax

Section 321(a) of the bill amends section 1401 of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on self-employment income.

Subsection (a) of the amended section 1401 provides a schedule of tax rates on self-employment income for old-age, survivors, and disability insurance. Under present law the rates of self-employment tax for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1962 (and before 1966)	5.4
1965 (and before 1968)	6.2
1967	6.9

Under the bill, the rates of self-employment tax for old-age, survivors, and disability insurance will be as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1969)	5.8
1968 (and before 1973)	6.7
1972	7.0

Subsection (b) of the amended section 1401 provides a schedule of tax rates on self-employment income for hospital insurance. The rates of self-employment tax provided for hospital insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1967)	0.325
1966 (and before 1971)	.50
1970 (and before 1973)	.55
1972 (and before 1976)	.60
1975 (and before 1980)	.65
1979 (and before 1987)	.75
1986	.85

The new section 1401(b) provides that, for purposes of the tax imposed for hospital insurance, the exclusion of employee representatives by section 1402(c)(3) of the code will not apply. Thus, the performance of service by an individual as an employee representative, as defined in section 3231(c) of the code (the Railroad Retirement Tax Act), is included in the term "trade or business" as defined in section 1402(c) for purposes of the tax imposed by the new section 1401(b)—but it should be noted that this change would not be made if section 111(d)(4) of the bill becomes effective.

Taxes on employees and employers

Section 321(b) and 321(c) of the bill amend section 3101 and section 3111, respectively, of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on wages for both employees and employers.

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide schedules of tax rates on wages for old-age, survivors, and disability insurance. Under present law the tax rates for employees and employers are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1963–65, inclusive	3⅝
1966–67, inclusive	4⅛
1968 and after	4⅝

Under the bill, the rates for employees and employers for old-age, survivors, and disability insurance will be as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966–68, inclusive	3.85
1969–72, inclusive	4.45
1973 and after	4.9

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide schedules of tax rates on wages

for hospital insurance. The employee and employer tax rates for hospital insurance are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966	0.325
1967–70, inclusive	.50
1971–72, inclusive	.55
1973–75, inclusive	.60
1976–79, inclusive	.65
1980–86, inclusive	.75
1987 and after	.85

For purposes of the employee tax and the employer tax imposed by the new sections 3101(b) and 3111(b), respectively, the exception from employment contained in paragraph (9) of section 3121(b) of the code is made inapplicable. Thus service performed by an employee as defined in section 3231(b) of the code (the Railroad Retirement Tax Act) constitutes employment, unless excluded under some paragraph (other than paragraph (9)) of section 3121(b), for purposes of determining wages subject to the employee and employer taxes imposed by the new sections 3101(b) and 3111(b)—but it should be noted that this change would not be made if paragraphs (5) and (6) of section 111(d) of the bill become effective.

Effective dates

Section 321(d) of the bill provides that the amendments made by section 321(a) will apply only with respect to taxable years which begin after December 31, 1965, and that the amendments made by sections 321(b) and 321(c) will apply with respect to remuneration paid after December 31, 1965.

SECTION 322. REIMBURSEMENT OF TRUST FUNDS FOR COST OF NONCONTRIBUTORY MILITARY SERVICE CREDITS

Section 322 of the bill amends section 217(g) of the Social Security Act to revise the provisions for the reimbursement of the trust funds for the cost of benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (1) of the revised section 217(g) provides that in September 1965 and in every fifth September thereafter up to and including September 2010, the Secretary of Health, Education, and Welfare will determine the amount which, if paid in equal annual installments, would be needed to place the old-age and survivors insurance, disability insurance, and hospital insurance trust funds in the same position at the end of June 2015 as they would be if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (2) of the revised section 217(g) authorizes annual appropriations to each of the trust funds in the amounts determined under paragraph (1) for each fiscal year in the 50 fiscal years, 1966–2015, as reimbursement for the cost of paying benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (3) of the revised section 217(g) authorizes a final appropriation to each of the trust funds for the fiscal year ending

June 30, 2016, to place the trust funds in the same position in which they would have been on June 30, 2015, if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (4) of the revised section 217(g) provides for annual appropriations to the old-age and survivors insurance, disability insurance, and hospital insurance trust funds to meet the costs of paying benefits after June 30, 2015, based on military service in the period from September 16, 1940, through December 1956.

SECTION 323. ADOPTION OF CHILD BY RETIRED WORKER

Section 323(a) of the bill amends section 202(d) of the Social Security Act (relating to child's insurance benefits) by striking out the last sentence in paragraph (1) (relating to adoptions by disabled workers) and by adding two new paragraphs (9) and (10). The new paragraph (9) of section 202(d) in effect retains the existing provisions relating to adoptions by disabled workers and makes such provisions applicable in the case where the worker is entitled to old-age insurance benefits and was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits. The effect of the new paragraph (10) of section 202(d) is to restrict the payment of child's insurance benefits when a child is adopted by a worker after the worker became entitled to old-age insurance benefits (without first becoming entitled to disability insurance benefits) by adding the following new requirements: (1) the child must have been living with the worker at the time the worker became entitled to old-age insurance benefits or adoption proceedings had begun at or before that time; (2) the child must have been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or before a period of disability began which continued until he became entitled to old-age insurance benefits; and (3) the adoption must have been completed within 2 years after the worker became entitled to old-age insurance benefits.

Section 323(b) of the bill provides that the new requirements (added by section 323(a)) will be effective with respect to applications for child's insurance benefits on or after the date of enactment of the bill. The requirement that adoption be completed within 2 years after the worker became entitled to benefits is not to apply in any case where a child is adopted within 1 year after the month in which the bill is enacted.

SECTION 324. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

Section 324(a) of the bill amends section 202(p) of the Social Security Act. The amended section 202(p) provides that in any case where the proof of support required in connection with an application for husband's insurance benefits, widower's insurance benefits, or parent's insurance benefits, or the application for a lump-sum death payment, is not filed within the 2-year period prescribed in the applicable sections of the law and where there was good cause for failure

to file such proof or application, the application or proof may be filed at any time after the expiration of the 2-year period and will be deemed to have been filed within that period. Under existing law an extension of only 2 additional years is provided in such cases.

Section 324(b) of the bill provides that the amendment made by subsection (a) will be effective with respect to monthly benefits and lump-sum death payments based on applications filed in or after the month of enactment of the bill.

SECTION 325. TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT TEST PURPOSES

Section 325(a) of the bill amends section 203(f)(5) of the Social Security Act, relating to the determination of a person's net earnings and net loss from self-employment for retirement test purposes, by adding a new subparagraph (D). The new subparagraph provides that, in determining the net earnings from self-employment of a beneficiary who has attained age 65, there is to be excluded in computing his gross income from a trade or business any royalties received in or after the year in which he attained age 65 if he shows to the satisfaction of the Secretary of Health, Education, and Welfare that the royalties are attributable to a copyright or patent which was obtained before the taxable year in which he attained age 65 and that the property to which the copyright or patent relates was created by his own personal efforts.

Section 325(b) of the bill provides that the changes made by subsection (a) will be effective for taxable years beginning after 1964.

SECTION 326. AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEMS

Section 326(a) of the bill makes a technical amendment to section 1(q) of the Railroad Retirement Act of 1937 to preserve the existing relationship between such act and title II of the Social Security Act. Under this amendment, references to the Social Security Act in the Railroad Retirement Act of 1937 will be considered to be references to the Social Security Act as amended in 1965.

Section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937, relating to situations where social security credits are transferred to the railroad retirement program. Benefits to survivors of a railroad employee are payable either under the railroad retirement program or the social security program, but not both, on the basis of the employee's combined earnings under both programs. In general, benefits are payable under the railroad retirement program if the individual has a current connection with the railroad industry at the time of his death. The compensation for railroad service is creditable up to $5,400 a year for this purpose. However, under present law, where an individual has less than the maximum of $5,400 in creditable compensation for a year, only enough of his earnings from employment subject to title II of the Social Security Act can be added to his compensation to increase the combined creditable earnings to $4,800, the present limit on earnings for a year under title II of the Social Security Act. To take into account

the increases made by section 320 of the bill in the maximum amount of annual earnings creditable under social security, section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937 to permit the crediting of earnings for a year in such an amount as to cause the combined total earnings to be as much as the new earnings and tax base under social security—$6,600 a year for years after 1965.

SECTION 327. TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS

Section 327 of the bill amends section 201(c) of the Social Security Act to require the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund to meet at least once each calendar year, rather than once each 6 months as required under present law. (A similar provision for annual meetings of the Board of Trustees is included in the provisions of the bill (discussed above) creating the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.)

SECTION 328. APPLICATIONS FOR BENEFITS

Section 328(a) of the bill amends section 202(j)(2) of the Social Security Act (relating to the life of applications for all monthly insurance benefits other than disability insurance benefits) to provide that an application for monthly benefits under section 202 filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. The amended section 202(j)(2) also provides that if upon final decision by the Secretary, or decision upon judicial review thereof, the applicant is found to satisfy the requirements for entitlement, the application shall be deemed to have been filed in such first month.

Section 328(b) of the bill makes conforming changes in section 216(i)(2) of the Social Security Act (relating to the life of applications for determinations of disability).

Section 328(c) of the bill makes conforming changes in section 223(b) of the Social Security Act (relating to the life of applications for disability insurance benefits).

Section 328(d) of the bill provides that the changes made by subsections (a), (b), and (c) will apply with respect to (1) applications filed on or after the date of enactment of the bill, (2) applications on which the Secretary has not made a final decision before the date of enactment of the bill, and (3) if a civil action has been commenced under section 205(g) of the Social Security Act before the date of enactment of this bill, applications as to which there has been no final judicial decision before the date of enactment of the bill.

SECTION 329. OVERPAYMENTS AND UNDERPAYMENTS

Section 329 of the bill substitutes a new subsection (a) for the present subsection (a) of section 204 of the act (relating to the adjustment of overpayments and underpayments), and a new subsection (b) for the present subsection (b) of section 204 (relating to waiver of adjustment or recovery of overpayments).

The new subsection (a) of section 204 of the act broadens the Secretary's authority to adjust overpayments and clarifies and broadens the Secretary's authority to adjust underpayments. Paragraph (1) of the new subsection (a) provides that where a person is paid more than the correct amount, the overpayment shall be adjusted, or recovered under regulations prescribed by the Secretary, by requiring the overpaid person or his estate to make a refund, or by decreasing any social security benefits payable to the overpaid person or to any other person on the earnings record that served as the basis of the benefit payments to the overpaid person. (Under present law, recovery from persons other than the overpaid person can be made only in cases where the overpaid person has died.)

Paragraph (2) of the new subsection (a) provides that where a person is paid less than the correct amount, the Secretary shall pay the balance due to the underpaid person. If the underpaid person dies before receiving the full amount due him, or after receiving but before negotiating checks representing the correct payments, the balance of the amount due, or the amount for which checks were properly issued but not negotiated, shall be paid under regulations prescribed by the Secretary in the order of priority which he determines will best carry out the purposes of the social security program. (Under present law, the Secretary has only very limited authority to dispose of underpayments in death cases; adjustment can be made only where the underpayment was the result of an error, and it can be adjusted only by adding the amount of the underpayment to the subsequent benefits of others getting benefits on the same earnings record as the deceased.)

The new subsection (b) of section 204 of the act broadens the Secretary's authority to waive adjustment or recovery of overpayments. Under present law, a condition for waiving adjustment or recovery of an overpayment is that the overpaid person be without fault; waiver is not authorized if the overpaid person is at fault even though the person from whom adjustment or recovery is sought is without fault. The new subsection (b) authorizes the Secretary to waive adjustment or recovery of an overpayment from any person who is without fault, even where he is not the overpaid person and the latter is at fault.

SECTION 330. PAYMENTS TO TWO OR MORE INDIVIDUALS OF THE SAME FAMILY

Section 330 of the bill substitutes a new subsection (n) for the present subsection (n) of section 205 of the act. The new subsection retains the provision of present law under which the Secretary may authorize a joint payment to two or more individuals of the same family equal to the total benefits due them, and adds a provision under which the Secretary of the Treasury may authorize the surviving

payee or payees of such a combined benefit check to cash one or more such checks which were not negotiated before one of the payees died, provided that the part (if any) of the proceeds from each check that represents an overpayment is to be adjusted or recovered as provided in section 204(a) of the act.

SECTION 331. VALIDATING ERRONEOUS EARNINGS REPORTED BY MINISTERS

Optional provision for certain certificates filed on or before April 15, 1967

Section 331 (a) of the bill amends section 1402(e) of the Internal Revenue Code of 1954 by striking out paragraphs (5) and (6) and adding a new paragraph (5). Pursuant to the new paragraph (5), any individual who has filed a certificate under section 1402(e) by April 15, 1965, and who has filed a timely return reporting earnings derived by him in any taxable year ending after 1954 from the performance of service as a minister, a member of a religious order (other than one who has taken a vow of poverty as a member of such order), or a Christian Science practitioner, but who does not have self-employment coverage for the first year for which such a return was filed because a certificate under section 1402(e) is not in effect with respect to such year, may have his self-employment coverage as a minister, member of a religious order, or Christian Science practitioner begin with such first year. The election may be made in the following manner:

Such an individual (or a fiduciary acting for such individual or his estate, or any survivor who is or may become entitled to monthly benefits under title II of the Social Security Act on his earnings record) as described above may file a supplemental certificate and indicate thereon an election to have the certificate previously filed by such individual made effective for the first taxable year ending after 1954 for which he filed such a return, and for all succeeding taxable years.

The new paragraph (5) also permits a survivor of an individual who died on or before April 15, 1965, and who had filed a timely return reporting his earnings in any taxable year ending after 1954 from the performance of service as a minister, a member of a religious order (as described above), or a Christian Science practitioner, but who failed to file a valid waiver certificate electing social security coverage, to file a waiver certificate effective with such first year. Such a certificate would be effective for the first taxable year ending after 1954 for which such deceased minister filed such a return, and for all succeeding years.

In either of the above two cases, if the supplemental certificate or the waiver certificate is to be valid, it must be filed on or before April 15, 1967, and all self-employment tax (whether or not attributable to earnings as a minister, member of a religious order, or Christian Science practitioner) due for each taxable year for which the certificate is effective under the new paragraph (5) must be paid on or before April 15, 1967. Moreover, any such tax previously refunded as an overpayment because no valid certificate was then in effect with respect to the year for which paid must be repaid to the United States, together with the interest allowed on the refund, on or before such date. However, any underpayment of the tax which is attributable to an error made in good faith will not invalidate an election which is otherwise valid. Any such tax which is paid or repaid for a year

with respect to which the period of limitation on assessment or collection has expired will not be regarded as an overpayment solely because such period has expired. It should be noted that April 15, 1967, falls on a Saturday, and section 7503 of the Code provides that an act required to be performed on a Saturday, Sunday, or legal holiday is timely if performed on the next day which is not a Saturday, Sunday, or legal holiday.

Administrative provisions

Pursuant to section 331(b) of the bill, no interest or penalty will be imposed with respect to self-employment tax paid on or before April 15, 1967, on earnings derived from the performance of service as a minister, member of a religious order, or Christian Science practitioner, for taxable years for which a certificate is effective under the new paragraph (5). In addition, the period for assessing taxes which become payable under the new paragraph (5) will expire not earlier than April 16, 1970.

Inclusion of earnings in social security records

Section 331(c) of the bill provides that notwithstanding the time limitation relating to the inclusion of self-employment income in social security records (sec. 205(c)(5)(F) of the Social Security Act), the Secretary of Health, Education, and Welfare may conform his records to tax returns or statements of earnings derived in any taxable year ending after 1954 which constitute self-employment income solely by reason of the filing of a certificate (or supplemental certificate) which is effective under section 1402(e)(5).

Effective dates

Section 331(d) of the bill provides that the amendments made by section 331 of the bill shall be applicable only with respect to certificates (and supplemental certificates) filed after the date of enactment of the bill. However, no monthly benefits under title II of the Social Security Act will be increased or payable by reason of such amendments for any month earlier than the month after the month of enactment of the bill and no lump-sum death payments under that title in the case of deaths prior to the date of enactment of the bill will be payable or increased by reason of such amendments.

SECTION 332. DETERMINATION OF ATTORNEY'S FEES IN COURT PROCEEDINGS UNDER TITLE II

Section 332 of the bill adds a subsection (b) to section 206 of the Social Security Act and changes the title of the section from "Representation of Claimants Before the Secretary" to "Representation of Claimants." Paragraph (1) of the new subsection permits a court that renders a favorable decision to a claimant in a case arising under the social security program to set a reasonable fee—not in excess of 25 percent of the total of the past due benefits which become payable as a result of the court's decision—for the attorney who represented the claimant before the court. Paragraph (1) also provides that, notwithstanding the provisions of section 205(i) of the Social Security Act (relating to certification by the Secretary of the amount of payments to be made), the Secretary may certify for payment to the attorney, out of the total of such past due benefits,

the amount of the fee set by the court. In the case of any such judgment, no other fee may be payable or certified for payment. Paragraph (2) provides that any attorney who demands or receives any additional amount for his services in representing the claimant before the court shall be guilty of a misdemeanor and subject to a fine of up to $500, or up to 1 year's imprisonment, or both.

SECTION 333. CONTINUATION OF WIDOW'S AND WIDOWER'S INSURANCE BENEFITS AFTER REMARRIAGE

Section 333(a) of the bill adds to the provisions for paying widow's insurance benefits a special provision for paying benefits to widows (not including surviving divorced wives) who remarry after attaining age 60, with the remarried widow's benefit for each month in which she is remarried equal to 50 percent of the primary insurance amount of the deceased husband.

Section 333(b) adds a similar provision to the present provisions for paying widower's insurance benefits to permit a widower who remarries after attaining age 62 to get a widower's insurance benefit equal to 50 percent of the primary insurance amount of the deceased wife for each month in which he is remarried.

Section 333(c) amends the present provisions under which a person who is simultaneously entitled to more than one dependent's benefit is paid the higher benefit, so that a person who is entitled to a widow's or widower's insurance benefit under the provisions of subsection (a) or (b) of this section would be paid the widow's or widower's benefit, and the other dependent's benefit would be reduced by the amount of the widow's or widower's benefit. While the law provides for withholding a wife's or husband's benefit payable on the current spouse's earnings record when the spouse works and earns enough to be subject to the retirement test, the provision for paying the widow's or widower's benefit first and then the difference between that and any other auxiliary benefit payable will mean that the remarried widow or widower will generally be able to get a benefit even if the new spouse works.

Section 333(d) provides that the effective date for paying the widow's and widower's insurance benefits to remarried people will be the second month after the month of enactment; in the case of people not entitled to widow's or widower's insurance benefits in the month after enactment, benefits would be payable on the basis of applications filed in or after the month of enactment.

SECTION 334. CHANGES IN DEFINITIONS OF WIFE, WIDOW, HUSBAND, AND WIDOWER

Section 334(a) of the bill amends the definition of "wife" in section 216(b) of the Social Security Act to include a woman who, in the month prior to the month of the marriage to the person on whose earnings record benefits are claimed, was actually or potentially entitled to a widow's, parent's, or (if she was over age 18) child's insurance annuity under section 5 of the Railroad Retirement Act. Sections 334 (b), (c), and (d) of the bill make similar amendments in the definitions of "widow," "husband" and "widower" in sections 216 (c), (f), and (g) of the Social Security Act.

Sections 334 (e) and (f) of the bill amend section 202(c)(2) (relating to husband's insurance benefits) and 202(f)(2) (relating to widower's insurance benefits) by making inapplicable the requirement that the wife or deceased wife be currently insured and the husband or widower have been dependent on her in order for him to receive husband's or widower's insurance benefits where he was actually or potentially entitled to a widower's, parent's, or (if he was over age 18) child's insurance annuity under section 5 of the Railroad Retirement Act in the month before his marriage to the person on whose earnings record benefits are claimed.

Section 334(g) of the bill provides that the changes made by section 334 shall be applicable only with respect to monthly insurance benefits under the Social Security Act beginning with the second month following the month of enactment on the basis of applications filed in or after the month of enactment.

SECTION 335. REDUCTION OF BENEFITS BASED ON DISABILITY ON ACCOUNT OF RECEIPT OF WORKMEN'S COMPENSATION

Section 335(a) of the bill adds a new section 224 to the Social Security Act which provides that where an individual is entitled to benefits under section 223 of the act there shall be a reduction in his benefits under section 202 and 223 of the act on account of concurrent receipt of periodic workmen's compensation benefits. The new section 224 will be applicable with respect to benefits payable for months after December 1965 based on applications filed after December 1965.

Clauses (1) and (2) of subsection (a) of the new section 224 provide that if for any month prior to the month in which an individual attains age 62 he is entitled both to benefits under section 223 and to periodic benefits under a workmen's compensation law or plan of the United States or a State, and if the Secretary has, in a prior month, received notice of such entitlement, the total of his benefits under section 223 for such month and any benefits under section 202 based on his wages and self-employment income shall be subject to reduction (but not below zero) as prescribed in the following clauses of this section. Clauses (3), (4), (5), and (6) of section 224(a) provide that the reduction shall be in the amount that the sum of such total of benefits under sections 223 and 202 and the periodic workmen's compensation benefit paid for such month exceeds the higher of 80 percent of the individual's "average current earnings" or the total of his disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section. Clauses (7) and (8) of section 224(a) provide that in no case shall the reduction for any month after the first month for which reduction is required under this section reduce such total of benefits payable under sections 223 and 202 to an amount that is less than the sum of the total of benefits under such sections 223 and 202 after reduction under this section for such first month and any increases in the benefits payable under this title effective after such first month with respect to the benefits payable to the disabled worker

and the persons entitled to benefits on his wages and self-employment income in the month such subsequent reduction is made.

An individual's "average current earnings" means the larger of (A) his average monthly wage (as defined in sec. 215) used in determining his disability insurance benefit under section 223 or (B) one-sixtieth of the total of his wages and self-employment income for the 5 consecutive calendar years after 1950 for which such wages and self-employment income were highest.

To illustrate the manner in which the reduction provision will operate: Assume that a worker, his wife and child are entitled to benefits under sections 202 and 223 for the month of March 1966 in the total amount of $244 and that the Secretary was notified in February 1966 that the worker has been receiving a periodic benefit for permanent and total disability under a State workmen's compensation law amounting to $48 a week ($208 per month). On these assumptions a total of $452 monthly would be paid under both programs. Assume, further, that the disabled worker's average monthly wage computed under section 215 of the Social Security Act equals $340 and that one-sixtieth of the wages and self-employment income credited to his social security account in his five highest consecutive years after 1950 equals $400. Eighty percent of the latter amount (the higher of these) equals $320. As a result, the total amount payable monthly under social security must be reduced by $132, the amount by which such total benefits under both programs exceeds $320. Therefore, the total family benefit payable for March 1966 under social security, after reduction under this section, will amount to $244 minus $132 ($112).. Furthermore, under clause (7) summarized above, any reduction for a future month for these beneficiaries may not result in a total social security benefit lower than the sum of $112 and any future benefit increases.

The new section 224(b) provides that where a periodic workmen's compensation benefit is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of or a substitute for periodic benefits), the reduction shall be made at such times and in such amounts as the Secretary determines will approximate as nearly as practicable the reduction prescribed in subsection (a) of this section. Since in some workmen's compensation cases, workers incur medical, legal, or related expenses in connection with their workmen's compensation claims, or in connection with the injuries they have suffered, and since the workmen's compensation awards are generally understood to include compensation for these expenses (except to the extent that special provision is made in the award to cover them or they are provided without cost to the worker), for purposes of this section the Secretary would not, in computing the amount of the periodic benefit payable to an individual under a workmen's compensation program, include any part of the workmen's compensation lump sum or benefit which he finds is equal to the amount of such expenses paid or incurred by the worker.

The new section 224(c) provides that reduction of benefits under this section shall be made after reduction under subsection (a) of section 203 (relating to reduction for the family maximum) but before deductions under sections 203 and 222(b). This requirement is intended to assure consistency between the provision for a reduction on

account of receipt of workmen's compensation (as provided in the new sec. 224) and the provisions of the present law governing adjustments, actuarial reductions, and deductions (such as deductions on account of earnings) which are generally applied cumulatively.

To illustrate the application of this section: Assume that a disabled worker "H," his wife "E" and two children "C_1" and "C_2" under age 18 are entitled to social security benefits in January 1967, and that the Secretary has been informed in December 1966 that "H" is receiving permanent and total disability benefits under a State workmen's compensation law. Assume further that H's social security average monthly wage is $340 resulting in a primary insurance amount (and a disability insurance benefit) of $122 per month (and a maximum family benefit of $273.60), and a benefit of $61 monthly, each, for E, C_1, and C_2 before application of the family maximum provisions of the schedule in section 215. Assume further, that H's "high five" average is $400 per month. On these assumptions application of this family maximum results in benefits (before the workmen's compensation reduction) as follows:

A	$122.00
E	50.60
C_1	50.60
C_2	50.60
Total	273.80

H's workmen's compensation benefit is $48 weekly ($208 per month) and the family total under both programs before reduction equals $481.80 ($273.80 plus $208).

Under the facts assumed above, the reduction would be $481.80 less $320 (80 percent of "high five" average), or $161.80. The social security family payable for January would thus be $273.80 less $161.80, or $112.

Assume that in February, E accepts a job paying $6,000 per year. In that case the social security benefit payable before reduction under this section would be:

A	$122
C_1	61
C_2	61
Total	244

The total benefits under both programs would then be $244 plus $208 which equals $452. The social security benefit would have to be reduced by $132 to $112 so that the total payable under both programs in February 1965 would be $320.

Similarly, suppose H, a disabled worker is entitled to disability benefits in January 1966 amounting to $135.90. Assume that H has a wife, aged 62, who is entitled to a reduced old-age benefit on her own record of $48 per month. After application of section 202(k) she would be entitled, in addition, to a wife's benefit as H's wife of $3 monthly. The reduction under this section would, of course, be computed on the basis of a total family disability benefit of $138.90, and charged against the same benefit.

Section 224(d) provides that there shall be no reduction under this section where the workmen's compensation law or plan under which the periodic benefit is paid contains any provision requiring a reduc-

tion of workmen's compensation when anyone entitled thereto is entitled to benefits under section 223.

Section 224(e) provides that the Secretary may require that an individual entitled to benefits under section 223 who may be eligible for periodic workmen's compensation benefits, certify whether he has or intends to file a claim for periodic workmen's compensation benefits, and if so, whether there has been a decision on such claim. This subsection further provides that the Secretary may rely upon such certification furnished by the individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205(i).

Paragraph (1) of section 224(f) provides that in the second calendar year after the year in which reduction of a disabled worker's social security benefit (and those of his dependents) was first required, and in each third year thereafter, the Secretary shall redetermine the amount of the benefits still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this title on the basis of such individual's wages and self-employment income. Such redetermination shall be determined as of, and shall be effective with the January following the year in which such redetermination was made.

Paragraph (2) of section 224(f) provides that in making the redetermination required under paragraph (1) of subsection (f), the individual's "average current earnings" (as defined in subsec. (a)) shall be deemed to be the product of his "average current earnings" as initially determined under subsection (a) and the ratio of (i) the average of taxable wages of all persons for whom taxable earnings were reported to the Secretary for the first calendar quarter of the calendar year in which the redetermination is made, to (ii) the average of the taxable wages of such persons reported to the Secretary for the first calendar quarter of the calendar year in which the individual's reduction was initially computed (but not counting any reduction made for benefits for a previous period of disability). . Any amount so determined which is not a multiple of $1 shall be reduced to the next lower multiple of $1.

Section 224(g) provides that whenever a reduction is made under this section in the total of benefits based on an individual's wages and self-employment income, each benefit, except the disability insurance benefit shall first be proportionately decreased, and any excess of the reduction that is required for such month over the sum of all such benefits other than the disability insurance benefits shall then be applied to such disability insurance benefit.

To illustrate the operation of this section (with special reference to the effects of subsecs. (f) and (g) and clause (7) of subsec. (a)), assume that a worker is disabled in an occupational accident in a certain future year and that he has a wife and one child under age 18. His workmen's compensation benefit is $48 a week, which is $208 on a monthly basis.

His "average monthly wage" that is used to compute his social security disability benefit is $420, and so his primary insurance amount is $140. Accordingly, his monthly social security disability insurance benefits before reduction, are $140 for himself, $70 for his wife, and $70 for his child—a total of $280.

His covered wages in his highest 5 consecutive years after 1950 totaled $27,000, or a monthly average of $450. Since the latter is higher than his "average monthly wage," it is used as his "average current earnings."

The monthly maximum initially applicable to his combined social security disability benefits and workmen's compensation benefits is then 80 percent of $450 or $360. Since the total of his workmen's compensation benefits and the unreduced social security disability benefits payable on his account is $488, the family's social security benefits must be reduced by $128. Accordingly, since the reduction is first applicable to the dependents' benefits, the reduced social security disability insurance benefits are as follows: Worker, $140; wife, $6; and child, $6 (a family total of $152 for social security and of $360 for the combined workmen's compensation and social security benefit).

Next, assume that legislation providing for a benefit increase for all OASDI beneficiaries is enacted and becomes effective in the next year and that this worker's primary insurance benefit is increased by $10 (to $150), which in turn would increase his wife's benefit by $5 (to $11) and his child's benefit by $5 (to $11). Under subsection (a) these increases are passed on to the disabled worker and his family, despite the 80-percent limitation.

Finally, assume that the average of the taxable wages of all persons for whom taxable wages were reported in the first calendar quarter of the year in which he was disabled was $1,200 and that such average for the second following year was $1,320, or 10 percent higher.

Accordingly, the "80 percent of average current earnings" limitation is increased, effective for January of the next year, from $360 to $396 per month. Thus, the family social security benefits have a monthly maximum of $188 (i.e., $396, minus the $208 workmen's compensation benefit). The disabled worker receives the full disability benefit of $150 (including the $10 increase provided by the across-the-board benefit increases after initial determination), and the wife and child each receive $19 per month.

If the redetermination of the "80 percent of average current earnings" limitation had been such as to increase the total of the workmen's compensation benefit and the family social security benefit from the initial $360 per month by $20 or less, then under clause (7) of subsection (a), the social security benefit payable would be unchanged—at $150 for the worker and $11 each for the wife and child (reflecting only the across-the-board benefit increases after initial determination).

SECTION 336. FACILITATING DISABILITY DETERMINATIONS

Section 336(a) of the bill amends section 221(b) of the Social Security Act so as to exclude the individuals referred to in section 221(g)(4) from the agreements with States for making disability determinations.

Section 336(b) of the bill amends section 221(g) of the Social Security Act to include among the individuals with respect to whom the Secretary will make the disability determinations referred to in section 221(a) of the Social Security Act (determinations of whether an individual is under a disability and of the day such disability began, and the determination of the day on which such disability ceases)

those individuals with respect to whom the Secretary, in accordance with regulations prescribed by him, finds that a determination of disability or cessation of disability can be made on the evidence furnished by or on behalf of such individuals from sources of information as to examination and treatment which are designated by such individuals, or on the evidence of remunerative work activities performed by such individuals.

Section 336(c) provides that the changes made by subsections (a) and (b) shall take effect in any State which has an agreement with the Secretary under section 221 when the Secretary finds that implementation of section 221(g)(4) of the Social Security Act can be effectuated with respect to individuals in such State without impeding the efficient administration of the disability insurance program in such State.

SECTION 337. PAYMENT OF COSTS OF REHABILITATION SERVICES FROM THE TRUST FUNDS

Section 337 of the bill amends section 222 of the Social Security Act by redesignating subsections (b) and (c) as subsections (c) and (d), respectively, and by inserting after subsection (a) a new subsection (b).

Paragraph (1) of the new subsection (b) provides that for the purpose of making vocational rehabilitation services more readily available to disabled individuals who are entitled to disability insurance benefits under section 223 or child's insurance benefits under section 202(d) after having attained age 18 (and who are under a disability), to the end that savings will result to the trust funds as a result of rehabilitating the maximum number of such individuals into productive activity, there are authorized to be transferred from the trust funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals (including services furnished during their waiting periods) and so much of the expenditures for the administration of any State plan as is attributable to carrying out this subsection. The total amount of the funds that may be made available from the trust funds for such purpose may not, in any fiscal year, exceed 1 percent of the benefits under section 202(d) for children who have attained age 18 (and are under a disability) or under section 223, which were certified for payment in the preceding year. The selection of individuals to receive such rehabilitation services, including the order of selection, shall be made in accordance with criteria formulated by the Secretary which are based upon the effect the provision of such services would have on the trust funds.

Paragraph (2) of the new subsection (b) provides that, in the case of each State willing to do so, such vocational rehabilitation services shall be furnished under a State plan which (*a*) has been approved under section 5 of the Vocational Rehabilitation Act; (*b*) provides that, to the extent funds provided under this subsection are adequate for the purpose, such services will be furnished with reasonable promptness to any person in the State meeting the criteria prescribed by the Secretary pursuant to paragraph (1) and in accordance with the order of selection determined under such criteria; and (*c*) provides that such services will be furnished to any individual without regard to his citizenship, place of residence, his need for financial assistance

(except as provided in regulations of the Secretary in the case of maintenance during rehabilitation), or any order of selection followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

Paragraph (3) of the new subsection (b) provides that where a State does not have a plan which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

Paragraph (4) of the new subsection (b) provides that payments under the new subsection (b) may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

Paragraph (5) of the new subsection (b) provides that money paid from the trust funds under this new subsection to pay the costs of providing services to individuals who are entitled to benefits under section 223 shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid out from the trust funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. According to such methods and procedures as he may deem appropriate, the Secretary is required to determine: (*a*) the total cost of the services provided under the new subsection (b), and (*b*) the amount of such cost which should be charged to each of the trust funds.

Paragraph (6) of the new subsection (b) provides that for the purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection.

SECTION 338. RETIREMENT SYSTEMS IN MAINE

Section 338 of the bill amends section 316 of the Social Security Amendments of 1958 to reopen such section until July 1, 1970, thereby extending to that date the time during which the State of Maine may, in modifying its coverage agreement under section 218 of the Social Security Act, deem a retirement system covering positions of teachers and positions of other employees to be a separate retirement system with respect to the positions of such teachers and a separate retirement system with respect to the positions of such other employees for social security coverage purposes.

SECTION 339. STUDENTS IN IOWA AND NORTH DAKOTA

Section 339 of the bill provides that the State of Iowa and the State of North Dakota may modify their agreements entered into pursuant to section 218 of the Social Security Act so as to exclude from social security coverage service performed in any calendar quarter in the employ of a school, college, or university by a student who is enrolled and is regularly attending classes at such school, college, or university if the remuneration for such services is less than $50. Such a modification would specify the effective date of the exclusion of such service, but the effective date could not be earlier than the enactment date of the bill.

SECTION 340. QUALIFICATION OF CHILDREN NOT QUALIFIED UNDER STATE LAW

Section 340(a) of the bill amends the Social Security Act by adding a new paragraph (3) to section 216(h) (relating to the determination of family status for social security benefit purposes) so as to make benefits payable on the basis of an insured worker's earnings to an applicant who is the son or daughter of the worker, but who cannot meet the definition of "child" under present law. Such an applicant will be considered the child of the worker if the worker (1) has acknowledged in writing that he is the child's father; (2) has been decreed by a court to be the child's father; (3) has been ordered by a court to contribute to the support of the child because he is the child's father; or (4) is shown by other evidence satisfactory to the Secretary to be the child's father and has been living with or contributing to the support of the child. The new paragraph (3) provides that in the case of a worker entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits), such acknowledgment, court decree, or court order must have occurred not less than 1 year before the worker became entitled to benefits or attained age 65, whichever is earlier, or the worker must have been living with or contributing to the support of the child at the time the worker became entitled to benefits or attained age 65, whichever is earlier. In the case of a worker who is entitled to disability insurance benefits (or was entitled to such benefits in the month preceding his entitlement to old-age insurance benefits), such acknowledgment, court decree, or court order must have occurred before such insured individual's most recent period of disability, or the worker must have been living with or contributing to the support of the child at the time the disability began. In the case of a deceased worker such acknowledgment, court decree, or court order must have occurred before the worker's death, or the worker must have been living with or contributing to the support of the child at the time he died.

Section 340(b) makes a conforming change in section 202(d) of the Social Security Act, which provides for the payment of child's insurance benefits.

Section 340(c) provides that the amendments made by section 340 shall apply with respect to benefits beginning with the second month following the month of enactment on the basis of applications filed in or after the month of enactment.

SECTION 341. EMPLOYEES OF MEMBERS OF AFFILIATED GROUP OF CORPORATIONS

Section 341(a) of the bill amends section 3121(a) of the Internal Revenue Code of 1954 (defining "wages" for social security tax purposes) by adding a new sentence at the end of paragraph (1) thereof. Paragraph (1) of section 3121(a) of the code provides, in part, a maximum annual limitation on wages subject to social security tax. The new sentence provides that under certain circumstances remuneration with respect to employment paid by a member of an affiliated group to an employee may be considered, for purposes of the maximum annual limitation, as having been paid to such employee

by another member of the affiliated group. The term "affiliated group," as used in the new sentence, means an affiliated group as defined in section 1504(a) of chapter 6 of the code (relating to consolidated returns) but determined without regard to sections 1504 (b) and (c) (relating to the definition of "includible corporation" and to includible insurance companies, respectively).

The new sentence applies only with respect to an employee who during a particular calendar year is employed by a member of an affiliated group after having been previously employed by a member (or members) of the same group in such year. Further, the new sentence applies only with respect to remuneration (other than remuneration which is excluded from "wages" by other paragraphs of sec. 3121(a)) with respect to employment. Such remuneration of a particular member of the group for a calendar year, for purposes of the maximum taxable earnings base, shall be considered to include any remuneration paid (or considered under this provision to have been paid) during such year by any other member of the group prior to his employment with the particular member. Thus, if individual A is employed by group member X from January 1 through June 30 and at some later time in the same calendar year performs services for group member Y, remuneration with respect to employment paid by X to employee A will be treated as having been paid by Y for the purpose of determining whether Y has paid to A during that calendar year remuneration with respect to employment equal to the maximum annual limitation on wages.

Section 341(b) provides that the amendment made by subsection (a) will apply only with respect to remuneration paid after 1965.

TITLE IV—PUBLIC ASSISTANCE AND MISCELLANEOUS AMENDMENTS

SECTION 401. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

Section 401(a) of the bill amends section 3(a)(1) of the Social Security Act. The first step of the formula by which Federal payments to States with approved plans for old-age assistance under title I are determined is changed so as to provide Federal sharing in 31/37ths of the first $37 of the average monthly assistance payment instead of 29/35ths of the first $35 of the average monthly assistance payment. The amendment also has the effect of applying the Federal percentage in the second step of the present formula to an additional $38, instead of the present additional $35, of the State's average payment. The additional Federal share in State expenditures for medical care, determined on the basis of the Federal medical percentage of the next $15 of a State's average payment, available under the third step of the present formula, is continued, thus giving under the formula as changed by the bill a potential Federal participation in State expenditures up to an average of $90. In addition, the formula is restated for the second and third steps, so as to give recognition to the State's expenditures for medical care before applying the Federal percentage to the remaining expenditures for which Federal participation is available.

The formula, as restated by section 401(a) of the bill, would pay States, in addition to the amount computed under section 3(a)(1)(A) of the Social Security Act, and in lieu of the amounts now computed under section 3(a)(1) (B) and (C) of such act, the larger of the following:

(i) (I) the Federal percentage (as defined in sec. 1101(a)(8)) of all expenditures for old-age assistance in excess of expenditures counted under clause (A), but not counting so much of the excess as exceeds $38 times the total number of recipients of old-age assistance; plus

(II) 15 percent of the State's expenditures in the form of medical care, up to a maximum of $15 times the total number of recipients of old-age assistance; or

(ii) (I) the Federal medical percentage (as defined in sec. 6(c)) of all expenditures in excess of expenditures counted under clause (i), but not counting expenditures that exceed (a) $52 times the total number of recipients, or (b) if smaller, the total expenditures for medical care plus $37 times the total number of recipients; plus

(II) the Federal percentage of all expenditures in excess of expenditures counted under clause (A) and the provisions of clause (B)(ii) described in these paragraphs (ii) (I) and (II), but not counting so much of the excess as exceeds $38 times the total number of recipients.

Section 401(b) of the bill makes corresponding changes in title XVI of the Social Security Act.

Section 401(c) of the bill amends section 403(a)(1) of the Social Security Act so as to change the formula by which the Federal share of aid to families with dependent children is determined. The present share of 14/17ths of the first $17 of the average monthly assistance payment is increased to 5/6ths of the first $18 of such payment. The ceiling for Federal participation is raised from $30 a month to $32 a month per recipient.

Sections 401(d) and 401(e) of the bill amend sections 1003(a)(1) and 1403(a)(1), respectively, of the Social Security Act so as to change the formula by which the Federal share of aid to the blind or aid to the permanently and totally disabled is determined. The present share of 29/35ths of the first $35 of the average monthly assistance payment is increased to 31/37ths of the first $37 of such payment, and the ceiling for Federal participation is raised from $70 a month to $75 a month per recipient.

Section 401(f) of the bill provides that the amendments made by the preceding provisions of section 401 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the act.

SECTION 402. PROTECTIVE PAYMENTS

Section 402 of the bill amends sections 6(a), 1006, 1405 and 1605(a) of the Social Security Act (as such sections are amended by sec. 221 of the bill), to extend the definitions of "old-age assistance," "aid to the blind," "aid to the permanently and totally disabled," and "aid to the aged, blind, or disabled" to include protective payments—i.e., payments made on behalf of the recipient to an individual who (as

determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of the recipient. The State plan under which the payments are made must include provision for—

(1) determination by the State agency that protective payments are necessary because, by reason of a physical or mental condition, the recipient is so unable to manage funds that payments to him would be contrary to his welfare;

(2) making payments in this form only when they (together with other income and resources) will meet all the needs of the individuals with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of aid or assistance paid;

(3) special efforts to protect the welfare of the recipient and to improve, to the extent possible, his capacity for self-care and ability to manage funds;

(4) periodic review by the State agency to determine whether payments in this form are still necessary, with provision for termination of such payments if not necessary and for seeking judicial appointment of a guardian or legal representative when such action will best serve the interests of the recipient; and

(5) opportunity for a fair hearing before the State agency on the determination that protective payments are necessary.

Section 402(e) of the bill provides that the amendments made by the preceding provisions of section 402 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the act.

SECTION 403. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER ASSISTANCE PROGRAMS FOR THE AGED, BLIND, AND DISABLED

Sections 403(a) and 403(c) of the bill amend sections 2(a)(10)(A) and 1602(a)(14) of the Social Security Act, effective January 1, 1966. These sections of the Social Security Act allow the States in determining need for old-age assistance or for aid to the aged, blind, or disabled (insofar as it relates to the aged) to disregard, of the first $50 per month of earned income, not more than the first $10 thereof plus one-half of the remainder. Under the amendments made by the bill, these amounts would be increased to $80 and $20, respectively; thus, in determining need for such assistance or aid, the State agency may disregard, of the first $80 of earned income for any month, not more than the first $20 thereof plus one-half of the remainder.

Sections 403(b) and 403(c) of the bill amend sections 1402(a)(8) and 1602(a)(14) of the act to extend this same exclusion of income to any individual claiming aid to the permanently and totally disabled or aid to the aged, blind, or disabled (insofar as it relates to the disabled). Thus, with respect to such individuals the State would be authorized to disregard, of the first $80 of earned income for any month, not more than the first $20 thereof plus one-half of the remainder. Under such amendments States may also disregard, for a period not in excess of 36 months, such additional amounts of other income and resources as may be necessary to the fulfillment of such an individual's approved plan for achieving self-support, but only as

to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation.

SECTION 404. ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC ASSISTANCE DETERMINATIONS

Section 404 of the bill amends title XI of the Social Security Act by adding a new section 1116 designed to provide for administrative and judicial review of certain administrative determinations made after December 31, 1965, with respect to State plans under the public assistance titles of such act (including the new title XIX added by sec. 121 of the bill).

Under the new section 1116(a)(1), the Secretary of Health, Education, and Welfare must, not later than 90 days after a State submits a plan to him for approval under one of the public assistance titles, make a determination as to whether it fulfills the conditions for approval specified in such title. Such 90-day period may be extended by written agreement of the Secretary and such State.

Section 1116(a)(2) provides that a State which is dissatisfied with such a determination may, within 60 days of notification thereof, petition the Secretary to reconsider his determination of disapproval. The Secretary must within 30 days after receipt of such petition schedule a hearing and notify the State of the time and place. The hearing must be held not less than 20 days nor more than 60 days after the date the State is given notice thereof, unless the Secretary and the State agree in writing to another time. The decision of the Secretary to affirm, modify, or reverse his original determination must be made within 60 days after the hearing is concluded.

Section 1116(a)(3) provides that a State which is dissatisfied with a final determination by the Secretary on such a reconsideration or with his final determination (to withhold funds) under section 4, 404, 1004, 1404, or 1604 of the Social Security Act, or under section 1904 of such act (as added by sec. 121(a) of the bill), may, within 60 days of notification thereof, petition the United States court of appeals for the circuit in which the State is located to review such determination. The clerk of such court will forthwith transmit a copy of the petition to the Secretary, who will thereupon file in the court the record of the administrative proceedings as provided in 28 U.S.C. 2112.

Section 1116(a)(4) makes the Secretary's findings of fact conclusive if they are supported by substantial evidence. The court is authorized, for good cause shown, to remand the case to the Secretary to take further evidence. In such case, the Secretary may make new or modified findings of fact and may modify his previous action, and he will certify to the court the record of such additional proceedings. Such findings of fact will likewise be conclusive if supported by substantial evidence.

Section 1116(a)(5) vests jurisdiction in the court to affirm the Secretary's action or to set it aside, in whole or in part. The judgment is reviewable by the Supreme Court upon certiorari or certification as provided in 28 U.S.C. 1254.

Section 1116(b) provides that, for purposes of obtaining the administrative and judicial reviews authorized under the new section 1116(a), any amendment of an approved State plan may, at the State's option, be treated as the submission of a new State plan.

Section 1116(c) provides that action pursuant to an initial determination of the Secretary described in section 1116(a) is not to be stayed pending reconsideration. In the event, however, that the Secretary subsequently determines that such initial determination was incorrect, the funds incorrectly withheld or otherwise denied must be restored to the State forthwith in a lump sum.

Section 1116(d) provides that the State is entitled to and upon request must receive reconsideration of any determination by the Secretary to disallow Federal financial participation in any item or class of items for which the State claimed such participation under a public assistance title of the Social Security Act (including the new title XIX, added by the bill).

SECTION 405. MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

Section 405 of the bill amends title XI of the Social Security Act by adding a new section 1117 designed to assure the maintenance of State effort in the financing of approved State plans under the public assistance titles of such act.

The new section 1117(a) provides that any increase in the Federal payments to a State for any quarter in the period January 1, 1966, through June 30, 1969—i.e., the increase in the total of the amounts otherwise payable for such quarter pursuant to determinations made under sections 3, 403, 1003, 1403, and 1603 of such act and under section 1903 of such act (as added by section 121(a) of the bill)—will be reduced to the extent that the State has not maintained expenditures from State and local funds of at least the same amount as was spent under its approved plans in a base period against which current quarter expenditures would be measured.

The amount of the reduction, if any, for a current quarter would be the amount by which—

(1) the excess of (A) the total of the Federal shares determined for the State under all of the sections of the act referred to above for such quarter over (B) the total of the Federal shares determined under sections 3, 403, 1003, 1403, and 1603 of the Act for the same quarter of fiscal year 1965, is greater than

(2) the excess of (A) the total expenditures for the current quarter under all of the State's approved plans (including its plan under the new title XIX) over (B) the total of the expenditures under all of its plans under titles I, IV, X, XIV, and XVI for the same quarter of fiscal year 1965.

The new section 1117(a) also gives the State the option to substitute (with respect to each of the quarters of any fiscal year) for the amount determined under paragraph (1)(B) above—

(3) the total of the Federal shares determined for the State for the same quarter in fiscal year 1964; or

(4) the average of the totals determined for each quarter in fiscal year 1964 or fiscal year 1965.

If the State elects the substitution under paragraph (3), there will be substituted for the amount determined under paragraph (2)(B) the total expenditures under its plans approved under titles I, IV, X, XIV, and XVI for the quarter referred to in paragraph (3). If the State elects the substitution under paragraph (4) for either of the years

referred to therein, there will be substituted for the amount determined under paragraph (2)(B) the average of the total expenditures under such approved plans for each quarter in the same fiscal year. Where the State has elected to substitute under paragraph (3) or (4), that election will apply with respect to all quarters in the fiscal year for which the substitution (under par. (3) or (4), as the case may be) has been elected.

The new section 1117(b) provides that expenditures under any or all plans of a State approved under title I, IV, X, XIV, XVI, or XIX (as added by the bill), and the reduction determined with respect thereto under such section 1117, will be determined on the basis of data in the quarterly reports of the State to the Secretary pursuant to and in accordance with his requirements under such titles; and determinations so made will be conclusive for purposes of such new section.

The new section 1117(c) provides that if a reduction is required under section 1117 (a) and (b) in the total of the Federal shares determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 (as added by the bill) for any quarter, the Secretary is to determine which of such amounts should be reduced and the extent thereof in such way as he deems will best further the purpose of maintaining State effort under the State's federally aided public assistance programs, and with the total of such reductions equaling the reduction required under section 1117 (a) and (b).

SECTION 406. DISREGARDING OASDI BENEFIT INCREASE, AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18, TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Section 406 of the bill permits a State, notwithstanding the requirements in titles I, IV, X, XIV, and XVI of the Social Security Act for the consideration of income and resources in determining need for aid or assistance under a plan of the State approved under any such title, to disregard the amount of any OASDI monthly insurance payment (or payment under the Railroad Retirement Act of 1937 by reason of sec. 326(a) of this bill) to a beneficiary which is attributable to any one or more of the months between December 1964 and the third month following the month in which this bill becomes law, but only to the extent it is also attributable (1) to the increase in such insurance benefits resulting from the enactment of section 301 of the bill, or (2) to the payment of child's insurance benefits after attainment of age 18, in the case of children attending school, resulting from the enactment of section 306 of the bill.

SECTION 407. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 407 of the bill provides that, notwithstanding section 701 of the Economic Opportunity Act of 1964 (enacted August 20, 1964), funds to which a State is otherwise entitled under the public assistance titles of the Social Security Act (including title XIX as added by the bill) for any period before the first month following the month of adjournment of the State's first regular legislative session adjourning after August 20, 1964, will not be withheld because of action taken pursuant to a statute of the State which prevents the State from complying with the requirements of section 701(a) of the Economic Opportunity Act of 1964 (relating to the disregard of certain income in determining need for federally aided public assistance).

SECTION 408. AMENDMENTS RELATING TO PUERTO RICO, VIRGIN ISLANDS, AND GUAM

Section 408 (a) and (b) of the bill changes the limitation in section 1108 of the Social Security Act on payments to Puerto Rico, the Virgin Islands, and Guam. These changes are effective for fiscal years beginning on or after the date on which the plan of any such jurisdiction under title XIX of such act (as added by the bill) is approved. The section also makes conforming changes to section 1112 of the act.

SECTION 409. OPTOMETRISTS' SERVICES

Section 409 provides that whenever payment is authorized under the Social Security Act for services that an optometrist is licensed to perform, the beneficiary has the freedom to select the services of either a physician skilled in diseases of the eye or an optometrist.

SECTION 410. ELIGIBILITY OF CHILDREN OVER AGE 18 ATTENDING SCHOOL

Section 410 of the bill amends section 406(a)(2)(B) of the Social Security Act so as to permit Federal financial participation in State payments of aid to families with dependent children for children age 18–21 regularly attending a school, college, or university. Provisions of present law, which remain in effect, include children 18–21 if they are regularly attending a vocational or technical training course designed to fit them for gainful employment.

SECTION 411. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED OF CERTAIN DEPENDENT CHILDREN

Section 411 of the bill amends section 402(a)(7) of the Social Security Act effective July 1, 1965, to permit a State, in determining need for aid to families with dependent children, to disregard not more than $50 per month of earned income of each dependent child under age 18 but not more than three in the same home.

INDIVIDUAL VIEWS

The undersigned have joined in these following views opposing enactment of the so-called medicare provisions of H.R. 6675 as amended by the majority of the members of the Senate Finance Committee.

We recognize as a fact that some of our aged citizens need governmental assistance to meet the cost of adequate medical care. But we are also convinced that many of the aged are capable of meeting their medical costs without Government assistance; thus the best solution has not been devised. We must oppose any legislation which would derive its financing from a compulsory tax on first dollars of wages earned by the Nation's working men and women to pay the hospital and other medical bills of the well-to-do and wealthy aged, most of whom are well able to meet such bills from their own resources. Such legislation produces an unequitable and unjustified tax burden on gross earnings of wage earners.

In addition, fiscal experts both in and out of the administration concede that a $6.8 billion annual brake will be applied to the Nation's economy. The $6.8 billion increase (to multiply in cost in later years) will not even cover early year program costs according to business actuaries and experts with experience in the health insurance and health care fields. They can prove their contention from health insurance claim experience and by the annual reports of countries which have enacted compulsory government health programs. Saskatchewan, for example, in less than 18 years shows an increase of 200 percent in hospital utilization by its aged. No such estimates were computed in arriving at an expected cost figure in this legislation. Costs in the British social security program have so skyrocketed that some responsible Englishmen prominent in the welfare field are now advocating a change so that only the needy would be aided in an effort to avoid bankruptcy of their entire welfare system.

Some advocates in this Congress, attempting to give assurance that the medicare program won't impair the retirement funds, point to the separate trust fund as though it would vouchsafe retirement dollars. This is illusory. Congress 10 years ago provided a separate trust fund for the disability program and our 10-year experience finds us in this very legislation having to rob the retirement fund. It is unfair that we impair the solvency of a program upon which many retired persons and millions more to retire in the future depend, at least as a retirement foundation.

We deplore the damage this legislation will do to our voluntary private insurance system. Its immediate effect will destroy private initiative for our aged to protect themselves with insurance against the costs of illness. More than 60 percent of our aged now purchase, without Government assistance, hospital and medical insurance. This private effort will cease if Government benefits are given to all aged. We anticipate that a Government health program for the aged will be extended to additional age groups of the population by the

same erroneous rationale which motivates the passage of this legislation to the extinction of the private insurance industry. A replacement of private sector activity in the health insurance industry could be repeated; in fact, other nations' experience dictates that it would be repeated regarding private hospitals, private medical schools, ad infinitum. The advocates of this legislation are already at work pointing out how the step taken in this bill represents merely the beginning of Government medical care for persons of all ages.

Compulsory Government health insurance is well along the way through our legislative process against the advice of the two most knowledgeable groups on the subject in our society—our physicians and our insurance industry. Ironically, the proponents of the legislation depend upon these two groups to make the legislation succeed. The insurance industry is to provide the expertise in making the arrangements with the providers of health services and health care, and only the physicians can certify a beneficiary for benefits by declaring his condition as "a medical necessity" requiring hospitalization, nursing home care, diagnostic care, home health services, or physician care.

We have urged the majority of the members of the committee to look to other methods to avoid killing private responsibility, or at least some degree of self-responsibility, including the use of deductibles and coinsurance to hold down the cost and to eliminate the "smack of socialism" implicit in a coverage-for-all program without avail. We have warned against imitating foreign country government type health programs, most of which have already experienced strife, financial difficulty, and a deterioration of the quality of medical excellence. We are proud of our medical system, which has produced the greatest progress in prolonging life and reducing the incidence of disease and sickness.

We plead that though the hour is late, it is never too late to do the right thing. Let's consult with our great medical profession and cease listening to voices of government witnesses who throughout the world have sung the siren songs which have resulted in mediocre government quality medicine replacing a far better system under which a free medical profession can continue to produce medical miracles for all mankind.

HARRY F. BYRD.
JOHN J. WILLIAMS.
WALLACE F. BENNETT.
CARL T. CURTIS.
THRUSTON B. MORTON.

SUPPLEMENTAL VIEWS

The bill H.R. 6675, as reported by this committee, is a historic, landmark measure. It represents the greatest advance in social legislation ever presented to the Congress of the United States. It proves once again the great contributions the legislative branch of our Government can make in improving and developing bold legislative proposals out of recommendations submitted to it by the executive branch.

The bill is a sign of America's maturity in facing up to its responsibilities to not only the aged, but to the young and the needy of all ages in our society. It gives us a threefold attack on the health cost problem of the aged—vastly expanded programs of maternal and child care—and long-overdue improvements in our welfare system.

The health insurance provisions of the bill reflect the belief that Government action should not be limited to measures that assist the aged only after they have become needy. The establishment of two separate but complementary health insurance programs will contribute greatly toward making economic security in old age a more realistic, more nearly attainable goal for most Americans. Because most of the aged could be expected to have the protection of the insurance program, public assistance would be relieved of much of its present burden. This would permit States to offer truly meaningful aid under the improved medical assistance provisions of the bill, to the few people who are in specially needy circumstances.

If the bill is lacking in any particular, it is that it fails to take a basic step to complete insurance protection for the aged against truly catastrophic illness. Despite the extension of inpatient hospital coverage to 120 days and extended nursing home care and home health visits, the individual suffering from an illness requiring even further care will see his life savings disappear rapidly when his term of benefits runs out. It is essential that insurance protection be extended to cover such an individual.

Having included in the House-passed bill additional coverage at a first year cost of $140 million, we should not lose this opportunity to do the whole job—to cover the most tragic cases—those cases of catastrophic illness which few individuals are equipped to handle alone. We can accomplish this for an additional $110 million first-year cost, giving us the truly comprehensive health insurance protection our older citizens need and deserve.

ABE RIBICOFF.
VANCE HARTKE.

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ADDITIONAL VIEWS

In the course of the committee's consideration of the bill, I proposed certain changes. Initially, these proposals were adopted by the committee; but, by subsequent action, the initial approval was reversed and the proposals rejected. Because I believe these amendments involved matters of importance, both for the substance of the program of medical care for the aged at the present time and in the larger context in which further legislation for medical care will be considered in the future, I wish to record these considerations as I see them.

In proposing these amendments and pressing for their adoption in the committee, I was, in fact, merely continuing to support the same principles I have always favored. Last year, in the debate on the floor of the Senate, I stated my position as follows:

> I am willing to vote for more money to provide care for those who have difficulty in paying for it themselves, but this Senator is reluctant to vote for the complete dole.
>
> The complete dole is a program under which a millionaire might be placed on relief—and that is what it would amount to—when the working people would be taxed in order to provide medical care for the wealthy. The beneficiary would not be required to pay 5 cents of his own money for medical care. We would tax the general public to provide care for people who are ready, able, and willing to pay for it themselves.

Although I had earlier introduced in the Senate a rather broad substitute for the House-passed bill, I concluded that this substitute, despite its merits, had no chance of being adopted. I decided not to proceed with my efforts to obtain support for the substitute proposal, but to propose only limited changes. Accordingly, I proposed to the committee the following two amendments. The second of these amendments is described as it was later modified to simplify its administration, rather than as it was initially considered by the committee.

First, I proposed that the artificial limits in the bill on the hospital care and associated services be eliminated. It makes no sense to me to place such limits on these services unless it is clearly impracticable to provide the needed financing. The need to be hospitalized, or in a nursing home, is not determined by the ability of the patient to pay, or have his bill paid for him; it is determined by his illness and other personal circumstances.

Personally, I shall never agree that the Government is meeting its responsibilities if it is going to assume the major responsibility for insuring that our citizens receive adequate medical care, so long as the operation of the program places a doctor, and a hospital, in the position of having to discharge a patient before, in their professional judgment, he should be discharged. To me, it is as simple as that. All I wanted to have placed in the bill was the provision that a patient

because he was unable to pay his bill, would not be involuntarily discharged from a hospital or nursing home until his doctor concluded that he should be discharged.

Secondly, partly in order to provide the necessary financing without increasing the social security tax, I proposed that the portion of the cost of hospitalization and associated services to be paid by the patient be made more flexible, and related directly to the ability of the patient to pay. Instead of a flat deductible of $40 for everybody, regardless of financial resources, I proposed the following schedules:

Income bracket	*Deductible*
$1,500 or less	$40
$1,500 to $2,000	60
$2,000 to $3,000	125
$3,000 to $5,000	200
$5,000 to $10,000	300
$10,000 and over	500

I consulted the appropriate actuarial sources within the Department of Health, Education, and Welfare and received assurances that this proposal would provide sufficient additional revenues to make it unnecessary to increase the social security tax at the present time, and provide the protection for catastrophic illnesses which I was seeking under my first proposal.

Despite the care with which I developed my proposals, and these consultations with the HEW officials, I was viciously attacked in the press as soon as it became known that the committee had voted to support them. Mr. President, I should like to record some of the irresponsible and even slanderous statements which appeared in the press. Many of them were on the editorial pages of some of our more prominent newspapers.

The Baltimore Sun, in its June 21 edition, headlined its editorial "Long Versus Medicare." The Washington Post said that it was my purpose to "gut" the bill. In an editorial on June 24, the St. Louis Post Dispatch said my amendments were "apparently designed to kill the health care legislation" under consideration. The New York Times printed a letter to the editor which stated: "The only object visible in Senator Long's behavior is the destruction of the entire bill."

Another of the efforts of the Washington Post was an editorial in its issue of June 19 entitled "Back to Charity." The Philadelphia Bulletin headed its editorial of June 20 "This Is Medicare?" When my proposals are understood, it will be easy to see that these attacks were grossly unwarranted.

The Scripps-Howard papers, of which I saw only the Washington News and the New York World-Telegram & Sun, titled their editorial onslaught as "Medicare or Monstrosity?" This charge of creating an "administrative monstrosity" was one of the principal criticisms of my proposals, but I deny emphatically that this charge is even remotely true. Let me explain just what was involved. To the extent that additional administrative problems were introduced by my amendments, they involved the difference in the deductible and in determining in which of the six income brackets the individual patient belonged. I gave close attention to these administrative problems, and believe they could be handled readily.

As regards the difference in the deductible, once the amount is determined, I fail to see any serious difficulty. In any situation under

the bill, the patient pays a certain amount of his charges; it is a simple matter of arithmetic. It involves the simple accounting process of subtracting the deductible from the total amount of the bill. If it is argued that a complication is introduced because any hospitalization immediately consumes the $40 deductible, while the $500 deductible might mean that the entire amount for a first hospitalization was paid by the patient, thus making it necessary to carry over the amount spent to apply on the next hospitalization, again no problem is posed for the administrator of the program.

The patient has the responsibility of meeting the smaller bills and accumulating them until he reaches a point where the Government should start paying his bills. I see nothing wrong whatever with this, especially as we are talking about a person who has an annual income of more than $10,000 per year, and, as will be noted below, almost certainly has private insurance to cover far more than the amount of $500 in hospital bills.

A more serious problem exists with regard to determining income. If we were dealing with a matter of tax liability, this argument would indeed have some merit, and all we have to do is look at the staggering size of the Internal Revenue Code and all the regulations and rulings which the Internal Revenue Code has built up in seeking to achieve complete equity between individuals under the tax laws. Fortunately, we need not be concerned here with that degree of hair splitting; instead we should turn for a precedent to the many other Government programs which provide benefits to individuals, and into which provisions have been written for determining income for the particular purposes of the program.

What I proposed, therefore, was that the Secretary of Health, Education, and Welfare be given free rein to handle this problem by regulation, thus permitting him to minimize the administrative problems. I have no doubt that he could solve the problems, and am confident that his Department and the other agencies which have administered our social security laws in the past 30 years have solved many that were far more complicated. In this case, however, the signals were set hard against my proposals, and mountains were made out of mole hills.

Once the determinations were made as to what was to be included or excluded in income, horrendous pictures were then drawn about the difficulties of finding out what the truth was about each individual's income in the immediately preceding period. What I propose is what is done throughout the administration of social programs; you accept the statement of the applicant, after the representative of the agency has explained to him what the regulations of the Secretary say should be included. In this case, he would need only to check which one of the brackets his income fell within.

Such statements are made subject to the general fraud statutes of the Federal Government, and violators could be found and prosecuted. Indeed, they could be found more easily than under many other programs. The applicants, for the most part, will certainly have social security numbers and will be asked to record them on their applications. Now that the Internal Revenue accounts are being completely placed under the same number as the social security accounts are under, and the whole process mechanized, all that is required is to feed the number given by the applicant into the IRS machines and press the button. The only violations which we would be seeking

would be those who have understated their income, and we can be certain that they are all in the upper five brackets of my proposal and will, therefore, have filed returns. Again, I feel that the administrative problems of enforcement were not a serious obstacle; they were just made to seem to be.

In these efforts to find additional revenues to provide the additional protection which is needed by placing the burden on those most able to pay, I was struck by a rather curious situation. Usually, those who are being asked to pay more complain bitterly. They rage and rant that they are being victimized and discriminated against. In this instance, those who were being handed the bill are those with the most money, and we Democrats have long made much of the fact that the Republicans are the protectors of this group of our citizens. Yet, in the final showdown on the committee, every Republican on the committee voted for my proposals, and no Democrat other than myself voted for them. Those who boast of representing the interests of the little people were being offered benefits for their clients, at the expense of the clients of their political opponents, and they were looking this gift horse in his mouth all the way down to his tail.

As I stated above, I was only partly seeking additional revenues when I proposed that the deductibles be related to the income of the individual patient. There are other reasons why this is justifiable, and desirable in the present circumstances. In this country, contrary to the situation existing in Western Europe when those countries adopted various forms of socialized medical care programs, we have developed under private initiative a truly amazing program of sharing the costs of our medical services on the insurance principle.

There is practically no employer of more than a few people who does not provide some type of hospitalization protection for his employees. For those who do not obtain protection in this way, it is one of their first concerns, especially upon marriage, and individual policies are available in virtually any combination of coverage.

Although the proportion of those over 65 who have such policies, or coverage through union trust funds and other institutional arrangements, is less than those in the more active worker age brackets, the proportion is very high. Almost two out of every three persons over 65 who are not living in an institution of some kind have some type of coverage. According to the Health Insurance Association of America, at the end of 1963 more than 61 percent of those in this group were protected in some measure, and virtually no policy fails to provide less than 30 days of hospitalization. Such a minimum provision, even averaged at $20 a day, will total more than the maximum deductible under my proposal.

If we then consider the fact that virtually half of those over 65 are in the first of the brackets under my proposal, and that they are the ones who do not have protection under the private schemes, it is easy to see why no one was screaming about victimization. Those who would have to pay the higher deductibles under my amendment already have insurance arrangements which would pay the deductible for them, thus providing them with unlimited coverage at no cost to themselves other than to continue to pay the premiums on their existing policies. For those few who might not have this type of protection, the insurance companies would undoubtedly have pro-

vided a special policy, and the premium would certainly be well within their means.

At the same time that no injustice would have been perpetrated, and much needed protection would have been provided to our elder citizens, we would also have been acting to avoid the destruction of private arrangements which have thus far carried a burden the Federal Government has not seen fit to assume until now. To me, it is undesirable to thrust aside the results of this private initiative—unless it is clearly not feasible to continue to provide some area for it to operate in. Yet, that is what the present bill will do for those over 65; and, since it appears to be the intention of those who are pressing this measure to extend its benefits under the same formula to those in the lower age brackets, ultimately, the whole of this development may well be swept away.

To summarize, the purposes my proposed changes were intended to serve were:

(1) To provide now benefits under the medicare program which are urgently needed, especially by those who are least able to pay. I am certain that it will only be a matter of time until full catastrophic coverage is provided under part A of the legislation.

(2) To finance these additional benefits in a manner which is in full accord with the principle of having the burden borne by those who are best able to pay. Under existing circumstances as explained, little in the way of a burden would have been added in actuality.

(3) To retain, to the extent consistent with the objectives of the medicare program and to use to best advantage, the private insurance coverage which already exists for hospitalization and associated services. This purpose will become increasingly important as further extensions of the medicare program are considered.

(4) To reassure the professional people on whose services and dedication to the welfare of their patients the entire program depends that continuing efforts will be made to keep a major portion of medical care within the private sector. We read almost daily of strikes and other disruptions of medical services in such countries as Great Britain and Belgium, even though these countries did not have the private insurance programs for their protection which now exist here. I believe we should try strenuously to handle the program in this country in a manner which will obtain the greatest degree of cooperation from our doctors and nurses, who are deeply and justifiably disturbed at the prospect of having the Federal Government determine their pay and other conditions of employment.

The committee bill is a good bill as it is being reported, however, and I am in favor of the program which it will initiate. It is, in fact, one of the most important measures to be considered by Congress in many years. It is my intention, as floor manager, to support the committee bill and to see it through to passage by the Senate and by this Congress.

RUSSELL B. LONG.

SUMMARY TABLES OF OASDI AND HOSPITAL INSURANCE TAX RATES, ESTIMATED AGGREGATE TAXES, AND AMOUNT OF COMBINED TAX ON EMPLOYER AND EMPLOYEE AT MAXIMUM EARNINGS LEVEL

TABLE 1.—*Tax rate, tax base, and tax amount applicable to employers and employees (each) under present law and under House and Senate Finance Committee versions of H.R. 6675—Old age, survivors, and disability insurance program 1965–87 and after*

Year	Tax rate—Employer and employee (each) (percent)			Tax base			Tax per employee with wage equal to base wage under Finance Committee bill [1]							
							Amount of tax			Increase under House bill		Increase under Finance Committee bill		
	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Over present law	Over 1965	Over present law	Over House bill	Over 1965
1965	3.625	3.625	3.625	$4,300	$4,800	$4,800	$174	$174.00	$174.00					
1966	4.125	4.000	3.850	4,800	5,600	6,600	198	224.00	254.10	$26.00	$50.00	$56.10	$30.10	$80.10
1967	4.125	4.000	3.850	4,800	5,600	6,600	198	224.00	254.10	26.00	50.00	56.10	30.10	80.10
1968	4.625	4.000	3.850	4,800	5,600	6,600	222	224.00	254.10	2.00	50.00	32.10	30.10	80.10
1969–70	4.625	4.400	4.450	4,800	5,600	6,600	222	246.40	293.70	24.40	72.40	71.70	47.30	119.70
1971–72	4.625	4.400	4.450	4,800	6,600	6,600	222	290.40	293.70	68.40	116.40	71.70	3.30	119.70
1973–75	4.625	4.800	4.900	4,800	6,600	6,600	222	316.80	323.40	94.80	142.80	101.40	6.60	149.40
1976–79	4.625	4.800	4.900	4,800	6,600	6,600	222	316.80	323.40	94.80	142.80	101.40	6.60	149.40
1980–86	4.625	4.800	4.900	4,800	6,600	6,600	222	316.80	323.40	94.80	142.80	101.40	6.60	149.40
1987 and after	4.625	4.800	4.900	4,800	6,600	6,600	222	316.80	323.40	94.80	142.80	101.40	6.60	149.40

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

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

TABLE 2.—*Tax rate, tax base, and tax amount applicable to self-employed persons under present law and under House and Senate Finance Committee versions of H.R. 6675—Old age, survivors, and disability insurance program 1965–87 and after*

Year	Tax rate (percent)			Tax base			Tax per self-employed person with earnings equal to base earnings under Finance Committee bill							
							Amount of tax			Increase under House bill		Increase under Finance Committee bill		
	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Over present law	Over 1965	Over present law	Over House bill	Over 1965
1965	5.4	5.4	5.4	$4,800	$4,800	$4,800	$259.20	$259.20	$259.20					
1966	6.2	6.0	5.8	4,800	5,600	6,600	297.60	336.00	382.80	$38.40	$76.80	$85.20	$46.80	$123.60
1967	6.2	6.0	5.8	4,800	5,600	6,600	297.60	336.00	382.80	38.40	76.80	85.20	46.80	123.60
1968	6.9	6.0	5.8	4,800	5,600	6,600	331.20	336.00	382.80	4.80	76.80	51.60	46.80	123.60
1969–70	6.9	6.6	6.7	4,800	5,600	6,600	331.20	369.60	442.20	38.40	110.40	111.00	72.60	183.00
1971–72	6.9	6.6	6.7	4,800	6,600	6,600	331.20	435.60	442.20	104.40	176.40	111.00	6.60	183.00
1973–75	6.9	7.0	7.0	4,800	6,600	6,600	331.20	462.00	462.00	130.80	202.80	130.80	0	202.80
1976–79	6.9	7.0	7.0	4,800	6,600	6,600	331.20	462.00	462.00	130.80	202.80	130.80	0	202.80
1980–86	6.9	7.0	7.0	4,800	6,600	6,600	331.20	462.00	462.00	130.80	202.80	130.80	0	202.80
1987 and after	6.9	7.0	7.0	4,800	6,600	6,600	331.20	462.00	462.00	130.80	202.80	130.80	0	202.80

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

TABLE 3.—*Tax rate, tax base, and tax amount applicable to employers, employees, and self-employed persons under the House and Senate Finance Committee versions of H.R. 6675—Basic hospital insurance program, 1965–87 and after*

Year	Tax on employer, employee, and self-employed (each)					
	Under House bill			Under Senate Finance Committee bill		
	Tax rate (percent)	Tax base	Tax amount [1]	Tax rate (percent)	Tax base	Tax amount [1]
1965						
1966	0.35	$5,600	$19.60	0.325	$6,600	$21.45
1967	.50	5,600	28.00	.500	6,600	33.00
1968	.50	5,600	28.00	.500	6,600	33.00
1969–70	.50	5,600	28.00	.500	6,600	33.00
1971–72	.50	6,600	33.00	.550	6,600	36.30
1973–75	.55	6,600	36.30	.600	6,600	39.60
1976–79	.60	6,600	39.60	.650	6,600	42.90
1980–86	.70	6,600	46.20	.750	6,600	49.50
1987 and after	.80	6,600	52.80	.850	6,600	56.10

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

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

TABLE 4.—*Estimated aggregate taxes on employers, employees, and self-employed persons under present law and under House and Senate Finance Committee versions of H.R. 6675—Old-age, survivors, and disability insurance program, 1965–72, 1975, 1980, 1990, 2000, and 2025 and basic hospital insurance program, 1965–75, 1980, 1985, and 1990*

[In billions]

Year	Present law			House bill				Finance Committee bill			
	Old-age and survivors insurance program	Disability insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic hospital insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic hospital insurance program	Total
1965	$16.0	$1.2	$17.2	$16.0	$1.2	-------	$17.2	$16.0	$1.2	-------	$17.2
1966	18.5	1.2	19.7	18.5	1.8	$1.6	21.9	18.8	1.8	$1.5	22.1
1967	19.4	1.3	20.7	19.7	2.0	2.6	24.3	20.5	2.0	2.8	25.3
1968	22.2	1.3	23.5	20.3	2.1	2.8	25.2	21.3	2.1	3.0	26.4
1969	23.3	1.3	24.6	22.9	2.2	2.9	28.0	25.2	2.2	3.1	30.5
1970	24.0	1.4	25.4	24.0	2.2	3.0	29.2	26.7	2.3	3.2	32.2
1971	24.6	1.4	26.0	25.9	2.4	3.3	31.6	27.5	2.4	3.6	33.5
1972	25.2	1.4	26.6	27.2	2.5	3.5	33.2	28.4	2.4	3.8	34.6
1973	(1)	(1)	(1)	(1)	(1)	3.9	(1)	(1)	(1)	4.3	(1)
1974	(1)	(1)	(1)	(1)	(1)	4.1	(1)	(1)	(1)	4.5	(1)
1975	[2] 24.6	[2] 1.4	[2] 26.0	[2] 26.4	[2] 2.4	4.3	(3)	[2] 29.1	[2] 2.2	4.7	(3)
1980	[2] 26.5	[2] 1.5	[2] 28.0	[2] 30.7	[2] 2.6	6.1	(3)	[2] 31.5	[2] 2.4	6.6	(3)
1985	(1)	(1)	(1)	(1)	(1)	7.0	(3)	(1)	(1)	7.5	(3)
1990	[2] 30.3	[2] 1.7	[2] 32.0	[2] 35.1	[2] 3.0	9.0	(3)	[2] 36.0	[2] 2.8	9.6	(3)
2000	[2] 35.2	[2] 2.0	[2] 37.2	[2] 40.7	[2] 3.5	(1)	(3)	[2] 41.8	[2] 3.2	(1)	(3)
2025	[2] 43.7	[2] 2.5	[2] 46.2	[2] 50.5	[2] 4.3	(1)	(3)	[2] 51.8	[2] 4.0	(1)	(3)

[1] Not available.
[2] These are long-range estimates which assume level-earnings trends in the future; all other estimates are short-range estimates which assume increased-earnings from year to year.
[3] Since the constituents of these totals represent long-range and short-range estimates they are not combined here.

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

TABLE 5.—*Combined tax rate on employer and employee under present law and under House and Senate Finance Committee versions of H.R. 6675—Old-age, survivors, and disability insurance program and basic hospital insurance program, 1965–87 and after*

[In percent]

Year	Combined tax rate on employer and employee												
	Old-age, survivors, and disability insurance program			Basic hospital insurance program			Old-age, survivors, and disability insurance program and basic hospital insurance program						
										Change under House bill		Change under Finance Committee bill		
	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Over present law	Over 1965	Over present law	Over House bill	Over 1965
1965	7.25	7.25	7.25				7.25	7.25	7.25					
1966	8.25	8.00	7.70		0.70	0.65	8.25	8.70	8.35	+0.45	+1.45	+0.10	−0.35	+1.10
1967	8.25	8.00	7.70		1.00	1.00	8.25	9.00	8.70	+.75	+1.75	+.45	−.30	+1.45
1968	9.25	8.00	7.70		1.00	1.00	9.25	9.00	8.70	−.25	+1.75	−.55	−.30	+1.45
1969–70	9.25	8.80	8.90		1.00	1.00	9.25	9.80	9.90	+.55	+2.55	+.65	+.10	+2.65
1971–72	9.25	8.80	8.90		1.00	1.10	9.25	9.80	10.00	+.55	+2.55	+.75	+.20	+2.75
1973–75	9.25	9.60	9.80		1.10	1.20	9.25	10.70	11.00	+1.45	+3.45	+1.75	+.30	+3.75
1976–79	9.25	9.60	9.80		1.20	1.30	9.25	10.80	11.10	+1.55	+3.55	+1.85	+.30	+3.85
1980–86	9.25	9.60	9.80		1.40	1.50	9.25	11.00	11.30	+1.75	+3.75	+2.05	+.30	+4.05
1987 and after	9.25	9.60	9.80		1.60	1.70	9.25	11.20	11.50	+1.95	+3.95	+2.25	+.30	+4.25

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

TABLE 6.—*Combined tax on employer and employee under present law and under House and Senate Finance Committee versions of H.R. 6675*[1]*— Old-age, survivors, and disability insurance program and basic hospital insurance program, 1965–87 and after*

Year	Combined tax on employer and employee													
	Old-age, survivors, and disability insurance program			Basic hospital insurance program			Old-age, survivors, and disability insurance program and basic hospital insurance program							
										Increase under House bill		Increase under Finance Committee bill		
	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Under present law	Under House bill	Under Finance Committee bill	Over present law	Over 1965	Over present law	Over House bill	Over 1965
1965	$348.00	$348.00	$348.00				$348.00	$348.00	$348.00					
1966	396.00	448.00	508.20	$39.20	$42.90		396.00	487.20	551.10	$91.20	$139.20	$155.10	$63.90	$203.10
1967	396.00	448.00	508.20	56.00	66.00		396.00	504.00	574.20	108.00	156.00	178.20	70.20	226.20
1968	444.00	448.00	508.20	56.00	66.00		444.00	504.00	574.20	60.00	156.00	130.20	70.20	226.20
1969–70	444.00	492.80	587.40	56.00	66.00		444.00	548.80	653.40	104.80	200.80	209.40	104.60	305.40
1971–72	444.00	580.80	587.40	66.00	72.60		444.00	646.80	660.00	202.80	298.80	216.00	13.20	312.00
1973–75	444.00	633.60	646.80	72.60	79.20		444.00	706.20	726.00	262.20	358.20	282.00	19.80	378.00
1976–79	444.00	633.60	646.80	79.20	85.80		444.00	712.80	732.60	268.80	364.80	288.60	19.80	384.60
1980–86	444.00	633.60	646.80	92.40	99.00		444.00	726.00	745.80	282.00	378.00	301.80	19.80	397.80
1987 and after	444.00	633.60	646.80	105.60	112.20		444.00	739.20	759.00	295.20	391.20	315.00	19.80	411.00

[1] For employee with wage equal to or in excess of the tax base under the Senate Finance Committee bill.

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

SUMMARY TABLE OF FULL YEAR BENEFIT COSTS, NUMBER OF PERSONS AFFECTED, AND EFFECTIVE DATE OF ITEMS WITH COST IMPORTANCE IN H.R. 6675, FINANCE COMMITTEE VERSION

Item	Trust fund	General Treasury	Number of persons affected	Effective date
HEALTH CARE PROGRAMS (1967)	*Millions*	*Millions*		
1. Basic hospital	$2,358	$285	17,000,000 insured, +2,000,000 uninsured.	July 1966.
2. Voluntary supplementary		[1] 600	16,900,000 estimated [1]	January 1967.
3. MAA liberalization		200	8,000,000	January 1966.
Health care total	[2] 2,358	1,085		
OASDI AMENDMENTS (1966)				
7 percent benefit increase	1,470		20,000,000	January 1965 (retroactive).
Child's benefit to age 22	195		295,000 children	Do.
Broader definition of child	10		20,000 children and mothers.	2d month after month of enactment.
Child disabled at ages 18-21	10		do	Do.
Reduced age for widows	([3])		185,000 widows	Do.
Special benefits at age 72	140		355,000 aged	Do.
Disability definition	40		60,000 workers and dependents.	Do.
Retirement test	590		850,000	Taxable years ending after 1965.
OASDI total	2,455			
PUBLIC ASSISTANCE AND CHILD HEALTH (1966)				
Increase in formula		150	7,200,000	January 1966.
TB and mental exclusion		75	100,000 to 150,000	Do.
Maternal and child health, crippled children, special project grants, study.		61	No estimate available.	Fiscal 1966.
OAA income exemption		1	do	Jan. 1, 1966.
MAA definition		2	do	July 1, 1965.
Mental retardation projects		3	do	Fiscal 1966.
Aid to families with dependent children earnings exemption.		1	3,500 children	July 1, 1965.
Aid to the permanently and totally disabled earnings exemption.		1	5,000 persons	Jan. 1, 1966.
Child welfare services		5	No estimate	Fiscal 1966.
Public assistance total		299		
Grand total payroll insurance.	4,813			
Grand total general revenue		1,384		

[1] Based on an averaging of low- and high-cost estimates, and on averaging estimates of participation (87½ percent). Total benefit expenditure would be about $1 billion, with participants contributing $600,000,000.
[2] 1st year benefit expenditures not reflected in cost table: $165,000,000 for widows benefit, 1st year (no long-term cost); $600,000,000 in individual contributions for voluntary supplemental health plan.
[3] Excludes administrative cost.

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Calendar No. 389

89TH CONGRESS
1st Session

SENATE

REPT. 404
Part II

SOCIAL SECURITY AMENDMENTS OF 1965

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

TO ACCOMPANY

H.R. 6675

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

PART II

JUNE 30 (legislative day, JUNE 29), 1965.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
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Calendar No. 389

89TH CONGRESS, 1st Session } SENATE { REPT. 404, Part II

SOCIAL SECURITY AMENDMENTS OF 1965

JUNE 30 (legislative day, JUNE 29), 1965.—Ordered to be printed

Mr. LONG of Louisiana, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 6675]

The Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

PART II

CHANGES IN EXISTING LAW

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets; new matter is printed in italic; existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

* * * * * * *

State Old-Age and Medical Assistance Plans

Sec. 2. (a) A State plan for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged 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;

(3) 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;

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

(5) 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(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 State plan;

(8) provide that all individuals wishing to make application for 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, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) If the State plan includes old-age assistance—

(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income [; except that, in making such determination, of the first $50 per month of earned income

the State agency may disregard, after December 31, 1962, not more than the first $10 thereof plus one-half of the remainder]; *except that, in making such determination, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;*

(B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

(C) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; [and]

(11) if the State plan includes medical assistance for the aged—

(A) provide for inclusion of some institutional and some noninstitutional care and services;

(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

(C) 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 such assistance to individuals who are residents of the State but are absent therefrom;

(D) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

(E) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged 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, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan[.] ;

(12) if the State plan includes assistance to or in behalf of individuals 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 periodic 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 who would otherwise need care in such institutions, including appropriate medical treatment and other assistance; for services referred to in section 3(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; and

(13) if the State plan includes assistance to or in behalf of 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.

(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 assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for old-age assistance excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

Payment to States

Sec. 3. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended **[**during such quarter**]** *during each month of such quarter* as old-age assistance under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof)—

(A) **[**29/35**]** *31/37* of such expenditures, not counting so much of any expenditure with respect to **[**any month**]** *such month* as exceeds the product of **[**$35**]** *$37* multiplied by the

total number of recipients of old-age assistance for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received old-age assistance in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as old-age assistance in the form of medical or any other type of remedial care); plus

[(B) the Federal percentage (as defined in section 1101 (a)(8)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of $70 multiplied by the total number of such recipients of old-age assistance for such month; plus

[(C) the larger of the following; (i) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (B), not counting so much of any expenditure with respect to any month as exceeds (I) the product of $85 multiplied by the total number of such recipients of old-age assistance for such month, or (II) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of $70 multiplied by such total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of $15 multiplied by the total number of such recipients of old-age assistance for such month;]

(B) The larger of the following:

(i) (I) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of recipients of old-age assistance for such month, plus (II) 15 per centum of the total expended during such month as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such month as exceeds the product of $15 multiplied by the total number of recipients of old-age assistance for such month, or

(ii) (I) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditures with respect to such month as exceeds (a) the product of $52 multiplied by the total number of such recipients of old-age assistance for such month, or (b) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of $37 multiplied by such total number of such recipients,

plus (II) the Federal percentage of the amount by which the total expended during such month as old-age assistance under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B) (ii), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of such recipients of old-age assistance for such month;

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as old-age assistance under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof,) not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of $45 multiplied by the total number of such recipients of old-age assistance for such month, or (II) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of $37.50 multiplied by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of $7.50 multiplied by the total number of such recipients of old-age assistance for such month;

(3) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 6(c)) of the total amounts expended during such quarter as medical assistance for the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof); and

(4) in the case of any State whose State plan approved under section 2 meets the requirements of subsection (c) (1), an amount equal to the sum of the following proportions of the total amount expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

(A) 75 per centum of so much for such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of assistance under the plan to help them attain or retain capability for self-care, or (ii) other services, specified by the Secretary as likely to prevent or reduce de-

pendency, so provided to such applicants or recipients, or

(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of assistance under the plan, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such assistance; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the politicial subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act, are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff; and

(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for adminis-

tration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(5) in the case of any State whose State plan approved under section 2 does not meet the requirements of subsection (c)(1), and amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection, 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, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

(c)(1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 2 must provide that the State agency shall make available to applicants for recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.

(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration o f such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.

(d) 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 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 in the State 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 in the State 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.

* * * * * * *

Definitions

Sec. 6. [(a) For the purposes of this title, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care

recognized under State law in behalf of, needy individuals who are sixty-five years of age or older, but does not include—

[(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases, or

[(2) any such payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof, or

[(3) any such care in behalf of any individual, who is a patient in a medical institution as a result of a diagnosis that he has tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution as a result of such diagnosis, for forty-two days.]

(a) *For the purposes of this title, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution). Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 2 includes provision for—*

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

(b) For purposes of this title, the term "medical assistance for the aged" 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 sixty-five years of age or older [who are not recipients of old-age assistance] *who are not recipients of old-age assistance (except, for any month, for recipients of old-age assistance who are admitted to or discharged from a medical institution during such month* but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services;
(2) skilled nursing-home services;
(3) physicians' services;
(4) outpatient hospital or clinic services;
(5) home health care services;
(6) private duty nursing services;
(7) physical therapy and related services;
(8) dental services;
(9) laboratory and X-ray services;
(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(11) diagnostic, screening, and preventive services; and
(12) any other medical care or remedial care recognized under State law;

[except that such term does not include any such payments with respect to—

[(A) care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or

[(B) care or services for any individual, who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.]

except that such term does not include 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).

(c) For purposes of this title, the term "Federal medical 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 50 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 (i) the Federal medical percentage shall in no case be less than 50 per centum or more than 80 per centum, and (ii) the Federal medical percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8) (other than the proviso at the end thereof); except that the Secretary shall, as soon as possible after enactment of the Social Security Amendments of 1960, determine and promulgate the Federal medical percentage for each State—

(1) for the period beginning October 1, 1960, and ending with the close of June 30, 1961, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for the fiscal year ending June

30, 1961 (which promulgation of the Federal medical percentage shall be conclusive for such period), and

(2) for the period beginning July 1, 1961, and ending with the close of June 30, 1963, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for such period (which promulgation of the Federal medical percentage shall be conclusive for such period).

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund

Section 201. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Old-Age and Survivors Insurance Trust Fund". The Federal Old-Age and Survivors Insurance Trust Fund shall consist of the securities held by the Secretary of the Treasury for the Old-Age Reserve Account and the amount standing to the credit of the Old-Age Reserve Account on the books of the Treasury on January 1, 1940, which securities and amount the Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, and, in addition, such amounts as may be appropriated to, or deposited in, the Federal Old-Age and Survivors Insurance Trust Fund as hereinafter provided. There is hereby appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1941, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes (including interest, penalties, and additions to the taxes) received under subchapter A of chapter 9 of the Internal Revenue Code of 1939 (and covered into the Treasury) which are deposited into the Treasury by collectors of internal revenue before January 1, 1951; and

(2) the taxes certified each month by the Commissioner of Internal Revenue as taxes received under subchapter A of chapter 9 of such Code which are deposited into the Treasury by collectors of internal revenue after December 31, 1950, and before January 1, 1953, with respect to assessments of such taxes made before January 1, 1951; and

(3) the taxes imposed by subchapter A of chapter 9 of such Code with respect to wages (as defined in section 1426 of such Code), and by chapter 21 (*other than sections 3101(b) and 3111(b)*) of the Internal Revenue Code of 1954 with respect to wages (as defined in section 3121 of such Code) reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 after December 31, 1950, or to the Secretary of the Treasury or his delegates pursuant to subtitle F of the Internal Revenue Code of 1954 after December 31, 1954, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such subchapter or chapter 21 (*other than sections 3101(b) and 3111(b)*) to such wages, which wages shall be

certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports, less the amounts specified in clause (1) of subsection (b) of this section; and

(4) the taxes imposed by subchapter E of chapter 1 of the Internal Revenue Code of 1939, with respect to self-employment income (as defined in section 481 of such Code), and by chapter 2 (*other than section 1401(b)*) of the Internal Revenue Code of 1954 with respect to self-employment income (as defined in section 1402 of such Code) reported to the Commissioner of Internal Revenue on tax returns under such subchapter or 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 subchapter or chapter (*other than section 1401(b)*) to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns, less the amounts specified in clause (2) of subsection (b) of this section.

The amounts appropriated by clauses (3) and (4) shall be transferred from time to time from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, 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 clauses (3) and (4) of this subsection.

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, *and before January 1, 1966*, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, *and 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and so reported*, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

(2) ⅜ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his dele-

gate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, *and before January 1, 1966, and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965,* which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

(c) With respect to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (hereinafter in this title called the "Trust Funds") there is hereby created a body to be known as the Board of Trustees of the Trust Funds (hereinafter in this title called the "Board of Trustees") which Board of Trustees shall be 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 title called the "Managing Trustee"). The Commissioner of Social Security shall serve as Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each [six months] *calendar year.* It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Funds;

(2) Report to the Congress not later than the first day of March of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;

(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;

(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of the old-age and survivors insurance and Federal-State unemployment compensation program; and

(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.

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

(d) It shall be the duty of the Managing Trustee to invest such portion of the Trust Funds 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 obligation for purchase by the Trust Funds. Such obligations issued for purchase by the Trust Funds shall have maturities fixed with due regard for the needs of the Trust Funds 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 four 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 of 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.

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

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, respectively.

(g)[(1) The Managing Trustee is directed to pay from the Trust Funds into the Treasury the amounts estimated by him and the Secretary of Health, Education, and Welfare which will be expended, out of moneys appropriated from the general funds in the Treasury, during a three-month period by the Department of Health, Education, and Welfare and the Treasury Department for the administration of titles II and VIII of this Act and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, and chapters 2 and 21 of the Internal Revenue Code of 1954. Such payments shall be covered into the Treasury as repayments to the account for reimbursement of expenses incurred in connection with the administration of titles II and VIII of this Act and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, and chapters 2 and 21 of the Internal Revenue Code of 1954. There are hereby authorized to be made available for expenditure, out of either or both of the Trust Funds, such amounts as the Congress may deem appropriate to pay the costs of administration of this title. After the close of each fiscal year, the Secretary of Health, Education, and Welfare shall analyze the costs of administration of this title incurred during such fiscal year in order to determine the portion of such costs which should have been borne by each of the Trust Funds and shall certify to the Managing Trustee the amount, if any, which should be transferred from one to the other of such Trust Funds in order to insure that each of the Trust Funds

has borne its proper share of the costs of administration of this title incurred during such fiscal year. The Managing Trustee is authorized and directed to transfer any such amount from one to the other of such Trust Funds in accordance with any certification so made.] *(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.*

(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 Treausry, 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 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.

(2) The Managing Trustee is directed to pay from time to time from the Trust Funds into the Treasury the amount estimated by him as taxes *imposed under section 3101(a)* which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages (as defined in section 1426 of the Internal Revenue Code of 1939 and section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1950. 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 Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 and to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the 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. Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in the ratio

in which amounts were appropriated to such Trust Funds under clause (3) of subsection (a) of this section and clause (1) of subsection (b) of this section.

(3) Repayments made under paragraph (1) or (2) 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 either such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(h) Benefit payments required to be made under section 223, and benefit payments required to be made under subsection (b), (c), or (d) of section 202 to individuals entitled to benefits on the basis of wages and self-employment income of an individual entitled to disability insurance benefits, shall be made only from the Federal Disability Insurance Trust Fund. All other benefit payments required to be made under this title (*other than section 226*) shall be made only from the Federal Old-Age and Survivors Insurance Trust Fund.

Old-Age and Survivors Insurance Benefit Payments

Old-Age Insurance Benefits

Sec. 202. (a) Every individual who—

(1) is a fully insured individual (as defined in section 214(a)),

(2) has attained age 62, and

(3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained the age of 65,

shall be entitled to an old-age insurance benefit for each month, beginning with the first month after August 1950 in which such individual becomes so entitled to such insurance benefits and ending with the month preceding the month in which he dies. Except as provided in subsection (q), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 215(a)) for such month.

Wife's Insurance Benefits

[(b)(1) The wife (as defined in section 216(b)) of an individual entitled to old-age or disability insurance benefits, if such wife—

[(A) has filed application for wife's insurance benefits,

[(B) has attained age 62 or has in her care (individually or jointly with her husband) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of her husband, and

[(C) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of her husband,

shall be entitled to a wife's insurance benefit for each month, beginning with the first month after August 1950 in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: she dies, her husband dies, they are divorced a vinculo matrimonii, no child of her husband is entitled to a child's insurance benefit and she has not attained age 62, she becomes entitled to an old-age or disability

insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of her husband, or her husband is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

[(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband for such month.]

Wife's Insurance Benefits

(b)(1) The wife (as defined in section 216(b)) and every divorced wife (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such wife or such divorced wife—

(A) has filed application for wife's insurance benefits,

(B) has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced wife, is not married,

(D) in the case of a divorced wife, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

(i) if he had a period of disability which did not end before the month in which he became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time he became entitled to such benefits, or

(ii) if he did not have such a period of disability, at the time he became entitled to old-age insurance benefits, and

(E) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with the first month in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs—

(F) she dies,

(G) such individual dies,

(H) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 20 years immediately before the date the divorce became effective,

(I) in the case of a divorced wife, she marries a person other than such individual,

(J) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(K) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(L) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

(3) In the case of any divorced wife who marries—

(A) an individual entitled to benefits under subsection (f) or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

Husband's Insurance Benefits

(c) (1) The husband (as defined in section 216(f)), of a currently insured individual (as defined in section 214(b)) entitled to old-age or disability insurance benefits, if such husband—

(A) has filed application for husband's insurance benefits,

(B) has attained age 62,

(C) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual—

(i) if she had a period of disability which did not end prior to the month in which she became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time she became entitled to such benefits, or

(ii) if she did not have such a period of disability, at the time she became entitled to such benefits,

and filed proof of such support within two years after the month in which she filed application with respect to such period of disability or after the month in which she became entitled to such benefits, as the case may be, or if she did not have such a period, two years after the month in which she became entitled to such benefits, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of his wife,

shall be entitled to a husband's insurance benefit for each month, beginning with the first month after August 1950 in which he becomes so entitled to such insurance benefits and ending with the month preceding the month in which any of the following occurs: he dies, his wife dies, they are [divorced a vinculo matrimonii] *divorced*, or he becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of his wife, or his wife is not entitled

to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) The requirement in paragraph (1) that the individual entitled to old-age or disability insurance benefits be a currently insured individual, and the provisions of subparagraph (C) of such paragraph, shall (*subject to subsection (s)*) not be applicable in the case of any husband who—

(A) in the month prior to the month of his marriage to such individual was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (f) or (h); [or]

(B) in the month prior to the month of his marriage to such individual had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d)[.]; *or*

(C) in the month prior to the month of his marriage to such individual he was entitled to, or on application therefor and attainment of the required age (if any) would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

(3) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife for such month.

Child's Insurance Benifit

(d) (1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual if such child—

(A) has filed application for child's insurance benefits,

[(B) at the time such application was filed was unmarried and either (i) had not attained the age of eighteen or (ii) was under a disability (as defined in section 223(c)) which began before he attained the age of eighteen, and]

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time student and had not attained the age of 22, or (ii) is under a disability (as defined in section 223(c)) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

[shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: such child dies, marries, is adopted (except for adoption by a stepparent, grandparent, aunt, or uncle subsequent to the death of such fully or currently insured individual), or attains the age of eighteen

and is not under a disability (as defined in section 223(c)) which began before he attained such age.]

shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding whichever of the following first occurs—

(D) the month in which such child dies, marries, or is adopted (except for adoption by a stepparent, grandparent, aunt, or uncle subsequent to the death of such fully or currently insured individual),

(E) the month in which such child attains the age of 18 and is not under a disability (as so defined) and is not a full-time student during any part of such month,

(F) the first month after the month in which such child attains the age of 18 and, in such first month, is not under a disability (as so defined) and is not a full-time student during any part of such first month, but only if in the third month preceding such first month he was not under a disability,

(G) the month in which such child attains the age of 22 and is not under a disability (as so defined), but only if in the third month preceding such month he was not under a disability, or

(H) the third month following the month in which he ceases to be under such disability.

[Entitlement of any child to benefits under this subsection shall also end with the month preceding the third month following the month in which he ceases to be under a disability (as so defined) after the month in which he attains age eighteen.] Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. [In the case of an individual entitled to disability insurance benefits, the provisions of clause (i) of subparagraph (C) of this paragraph shall not apply to a child of such individual unless he (A) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual) or (B) was legally adopted by such individual before the end of the twenty-four month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, but only if (i) proceedings for such adoption of the child had been instituted by such individual in or before the month in which began the period of disability of such individual which still exists at the time of such adoption or (ii) such adopted child was living with such individual in such month.]

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father at the time specified in paragraph (1)(C) unless, at such time,

such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) *or section 216(h)(3)* shall, if such individual is the child's father, be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather at the time specified in paragraph (1)(C) if, at such time, the child was living with or was receiving at least one-half of his support from such stepfather.

(5) A child shall be deemed dependent upon his natural or adopting mother at the time specified in paragraph (1)(C) if such mother or adopting mother was a currently insured individual. A child shall also be deemed dependent upon his natural or adopting mother, or upon his stepmother, at the time specified in paragraph (1)(C) if, at such time, (A) she was living with or contributing to the support of such child, and (B) either (i) such child was neither living with nor receiving contributions from his father or adopting father, or (ii) such child was receiving at least one-half of his support from her.

(6) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (e), (f), (g), or (h) of this section or under section 223(a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) *but subject to subsection (s)*, not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under section 223(a) or this subsection, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or this subsection unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entitled to benefits under section 223(a), he is entitled, for the month following such last month, to benefits under subsection (a) of this section.

(7) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated under the preceding provisions of this subsection may again become entitled to such benefits (provided no event specified in paragraph (1) (D) has occurred) beginning with the first month thereafter in which he is a full-time student and has not attained the age of 22, or in which he is under a disability (as defined in section 223(c)) which began before he attained the age of 22, if he also meets the requirements of subparagraphs (A) and (B) of paragraph (1); and such reentitlement shall end thereafter in accordance with the provisions of subparagraph (D), (F), (G), or (H) of paragraph (1).

(8) For the purposes of this subsection—

(A) A "full-time student" is an individual who is in full-time attendance as a student at an educational institution, as determined

by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the institutions involved, except that no individual shall be considered a "full-time student" if he is paid by his employer while attending an educational institution at the request, or pursuant to a requirement, of his employer.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time student during any period of nonattendance at an educational institution at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an educational institution immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an educational institution immediately following such period.

(C) An "educational institution" is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a nonaccredited school or college or university whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited.

(9) In the case of—

(A) an individual entitled to disability insurance benefits, or

(B) an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

a child of such individual adopted after such individual became entitled to such disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1) (C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D) was legally adopted by such individual before the end of the 24-month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, but only if—

(i) proceedings for such adoption of the child had been instituted by such individual in or before the month in which began the period of disability of such individual which still exists at the time of such adoption (or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65), or

(ii) such adopted child was living with such individual in such month.

(10) If an individual entitled to old-age insurance benefits (but not an individual included under paragraph (9)) adopts a child after such individual becomes entitled to such benefits, such child shall be

deemed not to meet the requirements of clause (i) of paragraph (1) (C) unless such child—

(A) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(B) was legally adopted by such individual before the end of the 24-month period beginning with the month after the month in which such individual became entitled to old-age insurance benefits, but only if—

(i) such child had been receiving at least one-half of his support from such individual for the year before such individual filed his application for old-age insurance benefits or, if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, for the year before such period of disability began, and

(ii) either proceedings for such adoption of the child had been instituted by such individual in or before the month in which the individual filed his application for old-age insurance benefits or such adopted child was living with such individual in such month.

Widow's Insurance Benefits

(e) [(1) The widow (as defined in section 216(c)) of an individual who died a fully insured individual, if such widow—

[(A) has not remarried,

[(B) has attained age 62,

[(C) (i) has filed application for widow's insurance benefits, or was entitled, after attainment of age 62, to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which he died, or

[(ii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained age 62, and

[(D) is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of her deceased husband,

shall be entitled to a widow's insurance benefit for each month, beginning with the first month after August 1950 in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of her deceased husband.

[(2) Such widow's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of her deceased husband.]

(1) The widow (as defined in section 216(c)) and every surviving divorced wife (as defined in section 216(d)) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

(A) is not married,

(B) has attained [age 62] *age 60,*

(C)(i) has filed application for widow's insurance benefits, or was entitled, after attainment of age 62, to wife's insurance benefits,

on the basis of the wages and self-employment income of such individual, for the month preceding the month in which he died, or

(ii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained age 62,

(D) in the case of a surviving divorced wife who was not entitled to wife's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which he died, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

(i) at the time of his death (or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of his death), or

(ii) at the time he became entitled to old-age insurance benefits or disability insurance benefits (or, if such individual had a period of disability which did not end before the month in which he became entitled to such benefits, at the time such period began or at the time he became entitled to such benefits), and

(E) is no entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of such deceased individual,

shall be entitled to a widow's insurance benefit for each month, beginning with the first month in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of such deceased individual.

(2) [*Such*] *Except as provided in subsection (q) and paragraph (4) of this subsection, such widow's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of such deceased individual.*

[(3) In the case of any widow of an individual—

[(A) who marries another individual, and

[(B) whose marriage to the individual referred to in subparagraph (A) is terminated by his death which occurs within one year after such marriage and he did not die a fully insured individual the marriage to the individual referred to in clause (A) shall, for the purposes of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month prior to whichever of the following is the latest: (i) the month in which the death referred to in subparagraph (B) of the preceding sentence occurs, (ii) the twelfth month before the month in which such widow files application for purposes of this paragraph, or (iii) November 1956.]

[(4)] *(3)* In the case of a [widow] *widow or surviving divorced wife* who marries—

(A) an individual entitled to benefits under subsection (f) or (h) of this section, or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such [widow's] *widow's or surviving divorced wife's* entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) *but subject to subsection (s)*, not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

(4) If widow, after attaining the age of 60, marries an individual (other than one described in subparagraph (A) or (B) of paragraph (3)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (2) and subsection (q), such widow's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the husband dies or such marriage is otherwise terminated, shall be equal to 50 per centum of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based.

Widower's Insurance Benefits

(f)(1) The widower (as defined in section 216(g)) of an individual who died a fully and currently insured individual, if such widower—

(A) has not remarried.

(B) has attained age 62.

(C) has filed application for widower's insurance benefits or was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which she died.

(D)(i) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual at the time of her death or, if such individual has a period of disability which did not end prior to the month in which she died, at the time such period began or at the time of her death, and filed proof of such support within two years after the date of such death, or, if she had such a period of disability, within two years after the month in which she filed application with respect to such period of disability or two years after the date of such death, as the case may be, or (ii) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual, and she was a currently insured individual, at the time she became entitled to old-age or disability insurance benefits or, if such individual had a period of disability which did not end prior to the month in which she became so entitled, at the time such period began or at the time she became entitled to such benefits, and filed proof of such support within two years after the month in which she became entitled to such benefits, or if she had such a period of disability, within two years after the month in which she field application with respect to such period of disability or two years after the month in which she became entitled to such benefits, as the case may be, and

(E) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of his deceased wife,

shall be entitled to a widower's insurance benefit for each month, beginning with the first month after August 1950 in which he becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: he remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of his deceased wife.

(2) The requirement in paragraph (1) that the deceased fully insured individual also be a currently insured individual, and the provisions of subparagraph (D) of such paragraph, shall (*subject to subsection (s)*) not be applicable in the case of any individual who—

(A) in the month prior to the month of his marriage to such individual was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under this subsection or subsection (h); [*or*]

(B) in the month prior to the month of his marriage to such individual had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) [.]; *or*

(C) in the month prior to the month of his marriage to such individual he was entitled to, or on application therefor and attainment of the required age (if any), would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

(3) [Such] *Except as provided in paragraph (5), such* widower's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of his deceased wife.

(4) In the case of a widower who remarries—

(A) an individual entitled to benefits under subsection (*b*), (e), (g), or (h), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such widower's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) *but subject to subsection (s)* not be terminated by reason of such marriage.

(5) If a widower, after attaining the age of 62, marries an individual (other than one described in subparagraph (A) or (B) of paragraph (4)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (3), such widower's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the wife dies or such marriage is otherwise terminated, shall be equal to 50 per centum of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based.

Mother's Insurance Benefits

(g) (1) The widow and every [former wife divorced] *surviving divorced mother* (as defined in section 216(d)) of an individual who died a fully or currently insured individual if such widow or [former wife divorced] *surviving divorced mother*—

(A) [has not remarried] *is not married,*

(B) is not entitled to a widow's insurance benefit,

(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

(D) has filed application for mother's insurance benefits, or was entitled to wife's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which he died,

(E) at the time of filing such application has in her care a child of such individual entitled to a child's insurance benefit, and

[(F) in the case of a former wife divorced, was receiving from such individual (pursuant to agreement or court order) at least one-half of her support at the time of his death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and the child referred to in subparagraph (E) is her son, daughter, or legally adopted child and the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income]

(F) in the case of a surviving divorced mother—

(i) at the time of such individual's death (or, if such individual had a period of disability which did not end before the month in which he died, at the time such period began or at the time of such death)—

(I) she was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or

(II) she was receiving substantial contributions from such individual (pursuant to a written agreement), or

(III) there was a court order for substantial contributions to her support from such individual,

(ii) the child referred to in subparagraph (E) is her son, daughter, or legally adopted child, and

(iii) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income,

shall (*subject to subsection (s)*) be entitled to a mother's insurance benefit for each month, beginning with the first month after August 1950 in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, such widow or [former wife divorced] *surviving divorced mother* becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, she becomes entitled to a widow's insurance benefit, she remarries, or she dies. Entitlement to such benefits shall also end, in the case of a [former wife divorced] *surviving divorced mother*, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such [former wife divorced] *surviving divorced mother* is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

(2) Such mother's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

[(3) In the case of any widow or former wife divorced of an individual—

[(A) who marries another individual, and

[(B) whose marriage to the individual referred to in subparagraph (A) is terminated by his death but she is not, and upon filing application therefor in the month in which he died would not be, entitled to benefits for such month on the basis of his wages and self-employment income,

the marriage to the individual referred to in clause (A) shall, for the purpose of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month prior to whichever of the following is the latest: (i) the month in which the death referred to in subparagraph (B) of the preceding sentence occurs, (ii) the twelfth month before the month in which such widow or former wife divorced files application for purposes of this paragraph, or (iii) the month following the month in which this paragraph is enacted.]

[(4)] *(3)* In the case of a widow or [former wife divorced] *surviving divorced mother* who married—

(A) an individual entitled to benefits under subsection (a), (f), or (h), or under section 223(a), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such widow or [former wife divorced] *surving divorced mother* to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) *but subject to subsection (s)*, not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under section 223(a) or subsection (d) of this section, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or subsection (d) of this section unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entitled to benefits under section 223(a), he is entitled, for the month following such last month, to benefits under subsection (a) of this section.

Parent's Insurance Benefits

(h)(1) Every parent (as defined in this subsection) of an individual who died a fully insured individual if such parent—

(A) has attained age 62,

(B) (i) was receiving at least one-half of his support from such individual at the time of such individual's death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and (ii) filed proof of such support within two years after the date of such death, or, if such individual had such a period of disability, within two years after the month in which such individual filed application with respect to such period of disability or two years after the date of such death, as the case may be,

(C) has not married since such individual's death,

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of such deceased individual if

the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), and

(E) has filed application for parent's insurance benefits, shall be entitled to a parent's insurance benefit for each month beginning with the first month after August 1950 in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs: such parent dies, marries, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2) (A) (or 75 percent of such primary insurance amount in any other case).

(2) (A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of such deceased individual.

(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income, such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual.

(C) In any case in which—

(i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income, and

(ii) another parent of such deceased individual is entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent's benefits referred to in clause (i) was filed,

the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and the amount of the parent's insurance benefit of a parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of the deceased individual minus the amount (before the application of section 203(a)) of the benefit for such month of the parent referred to in clause (i).

(3) As used in this subsection, the term "parent" means the mother or father of an idividual, a stepparent of an individual by a marriage contracted before such individual attained the age of sixteen, or an adopting parent by whom an individual was adopted before he attained the age of sixteen.

(4) In the case of a parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (*b*), (e), (f), or (g), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such parent's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) *but subject to subsection* (*s*), not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under

subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

Lump-Sum Death Payments

(i) Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount, or an amount equal to $255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined by the Secretary to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

(1) if all or part of the burial expenses of such insured individual which are incurred by or through a funeral home or funeral homes remains unpaid, to such funeral home or funeral homes to the extent of such unpaid expenses, but only if (A) any person who assumed the responsibility for the payment of all or any part of such burial expenses files an application, prior to the expiration of two years after the date of death of such insured individual, requesting that such payment be made to such funeral home or funeral homes, or (B) at least 90 days have elapsed after the date of death of such insured individual and prior to the expiration of such 90 days no person has assumed responsibility for the payment of any of such burial expenses;

(2) if all of the burial expenses of such insured individual which were incurred by or through a funeral home or funeral homes have been paid (including payments made under clause (1)), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such burial expenses; or

(3) if any part of the amount payable under this subsection remains after payments have been made pursuant to clauses (1) and (2), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid other expenses in connection with the burial of such insured individual, in the following order of priority: (A) expenses of opening and closing the grave of such insured individual, (B) expenses of providing the burial plot of such insured individual, and (C) any remaining expenses in connection with the burial of such insured individual.

No payment (except a payment authorized pursuant to clause (1)(A) of the preceding sentence) shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953

and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, and who is returned to any State or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

Application for Monthly Insurance Benefits

(j)(1) An individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to the end of the twelfth month immediately succeeding such month. Any benefit *under this title* for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing or such application, the Secretary has certified for payment for such prior month.

[(2) No application for any benefit under this section for any month after August 1950 which is filed prior to three months before the first month for which the applicant becomes entitled to such benefit shall be accepted as an application for the purposes of this section; and any application filed within such three months' period shall be deemed to have been filed in such first month.]

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any

such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

Simultaneous Entitlement to Benefits

(k) (1) A child, entitled to child's insurance benefits on the basis of the wages and self-employment income of an insured individual, who would be entitled, on filing application, to child's insurance benefits on the basis of the wages and self-employment income of some other insured individual, shall be deemed entitled, subject to the provisions of paragraph (2) hereof, to child's insurance benefits on the basis of the wages and self-employment income of such other individual if an application for child's insurance benefits on the basis of the wages and self-employment income of such other individual has been filed by any other child who would, on filing application, be entitled to child's insurance benefits on the basis of the wages and self-employment income of both such insured individuals.

(2) (A) Any child who under the preceding provisions of this section is entitled for any month to more than one child's insurance benefit shall, notwithstanding such provisions, be entitled to only one of such child's insurance benefits for such month, such benefit to be the one based on the wages and self-employment income of the insured individual who has the greatest primary insurance amount.

(B) Any indivdual (*other than an individual to whom subsection (e)(4) or (f)(5) applies*) who, under the preceding provisions of this section and under the provisions of section 223, is entitled for any month to more than one monthly insurance benefit (other than old-age or disability insurance benefit) under this title shall be entitled to only one such monthly benefit for such month, such benefit to be the largest of the monthly benefits to which he (but for this subparagraph (B)) would otherwise be entitled for such month. *Any individual who is entitled for any month to more than one widow's or widower's insurance benefit to which subsection (e)(4) or (f)(5) applies shall be entitled to only one such benefit for such month, such benefit to be the largest of such benefits.*

(3)(*A*) If an individual is entitled to an old-age or disability insurance benefit for any month and to any other monthly insurance benefit for such month, such other insurance benefit for such month, after any reduction under subsection (q) and any reduction under section 203 (a), shall be reduced, but not below zero, by an amount equal to such old-age or disability insurance benefit (after reduction under such subsection (q)).

(*B*) *If an individual is entitled for any month to a widow's or widower's insurance benefit to which subsection (e)(4) or (f)(5) applies and to any other monthly insurance benefit under section 202 (other than an old-age insurance benefit), such other insurance benefit for such month, after any reduction under subparagraph (A), any reduction under subsection (q), and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under such subparagraph (A) and such section 203(a).*

(4) Any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a

disability insurance benefit under this title shall be entitled to only *the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.*

Entitlement to Survivor Benefits Under Raiload Retirement Act

(l) If any person would be entitled, upon filing application therefor to an annuity under section 5 of the Railroad Retirement Act of 1937, or to a lump-sum payment under subsection (f)(1) of such section, with respect to the death of an employee (as defined in such Act) no lump-sum death payment, and no monthly benefit for the month in which such employee died or for any month thereafter, shall be paid under this section to any person on the basis of the wages and self-employment income of such employee.

Minimum Survivor's or Dependent's Benefit

(m) In any case in which the benefit of any individual for any month under this section (other than subsection (a)) is, prior to reduction under subsection (k)(2) and subsection (q), less than the first figure in column IV of the table in section 215(a) and no other individual is (without the application of section 202(j)(1)) entitled to a benefit under this section for such month on the basis of the same wages and self-employment income, such benefit for such month shall, prior to reduction under such subsection (k)(3) and subsection (q), be increased to the first figure in column IV of the table in section 215(a).

Termination of Benefits Upon Deportation of Primary Beneficiary

(n) (1) If any individual is (after the date of enactment of this subsection) deported under paragraph (1), (2), (4), (5), (6), (7), (10) (11), (12,), (14,), (15), (16), (17), or (18) of section 241(a) of the Immigration and Nationality Act, then, notwithstanding any other provisions of this title--

(A) no monthly benefit under this section or section 223 shall be paid to such individual, on the basis of his wages and self-employment income, for any month occurring (i) after the month in which the Secretary is notified by the Attorney General that such individual has been so deported, and (ii) before the month in which such individual is thereafter lawfully admitted to the United States for permanent residence,

(B) if no benefit could be paid to such individual (or if no benefit could be paid to him if he were alive) for any month by reason of subparagraph (A), no monthly benefit under this section shall be paid, on the basis of his wages and self-employment income, for such month to any other person who is not a citizen of the United States and is outside the United States for any part of such month, and

(C) no lump-sum death payment shall be made on the basis of such individual's wages and self-employment income if he dies (i) in or after the month in which such notice is received, and (ii) before the month in which he is thereafter lawfully admitted to the United States for permanent residence.

Section 203 (b), (c), and (d) of this Act shall not apply with respect to any such individual for any month for which no monthly benefit may be paid to him by reason of this paragraph.

(2) As soon as practicable after the deportation of any individual under any of the paragraphs of section 241(a) of the Immigration and Nationality Act enumerated in paragraph (1) in this subsection, the Attorney General shall notify the Secretary of such deportation.

Application for Benefits by Survivors of Members and Former Members of the Uniformed Services

(o) In the case of any individual who would be entitled to benefits under subsection (d), (e), (g), or (h) upon filing proper application therefor, the filing with the Administrator of Veterans' Affairs by or on behalf of such individual of an application for such benefits, on the form described in section 3005 of Title 38, United States Code, shall satisfy the requirement of such subsection (d), (e), (g), or (h) that an application for such benefits be filed.

[Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment]

[(p) In any case in which there is a failure—

[(1) to file proof of support under subparagraph (C) of subsection (c)(1), clause (i) or (ii) of subparagraph (D) of subsection (f)(1), or subparagraph B of subsection (h)(l), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950 within the period prescribed by such subparagraph or clause, or

[(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection,

and it is shown to the satisfaction of the Secretary that there was good cause for failure to file such proof or application, as the case may be, within such period, such proof or application shall be deemed to have been filed within such period if it is filed within two years following such period or within two years following August 1956, whichever is later. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.]

Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment

(p) In any case in which there is a failure—

(1) to file proof of support under paragraph (C) of subsection (c)(1), clause (i) or (ii) of subparagraph (D) of subsection (f)(1), or subparagraph (B) of subsection (h)(1), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subparagraph or clause, or

(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act

Amendments of 1950, within the period prescribed by such subsection, any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Secretary that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.

Adjustment of Old-Age, Wife's, or Husband's Insurance Benefit Amounts in Accordance With Age of Beneficiary

Reduction of Old-Age, Disability, Wife's Husband's, or Widow's Insurance Benefit Amounts

(q) [(1) If the first month for which an individual is entitled to an old-age, wife's, or husband's insurance benefit is a month before the month in which such individual attains age 65, the amount of such benefit for each month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

[(A) ⅝ of 1 percent of such amount if such benefit is an old-age insurance benefit, or $^{25}/_{36}$ of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit; multiplied by

[(B) (i) the number of months in the reduction period for such benefit (determined under paragraph (5)), if such benefit is for a month before the month in which such individual attains age 65, or

[(ii) the number of months in the adjusted reduction period for such benefit (determined under paragraph (6)), if such benefit is for the month in which such individual attains age 65 or for any other month thereafter.]

(1) If the first month for which an individual is entitled to an old-age, wife's, husband's, or widow's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for each month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) 5/9 of 1 percent of such amount if such benefit is an old-age or widow's insurance benefit, or 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, multiplied by

(B) (i) the number of months in the reduction period for such benefit (determined under paragraph (6)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) the number of months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains retirement age or for any month thereafter.

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained age 65 in the first month for which he most recently became entitled to a disability insurance benefit.

[(2)] *(3)* (A) If the first month for which an individual both is entitled to a [wife's or husband's insurance benefit] *wife's, husband's, or widow's insurance benefit* and has attained [age 62] *age 62 (in the*

case of a wife's or husband's insurance benefit) or age 60 (in the case of a widow's insurance benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains age 65), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such [wife's or husband's insurance benefit] *wife's, husband's, or widow's insurance benefit* for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance [benefit,] *benefit and is not entitled to a disability insurance benefit,* such individual's wife's or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph [(1)] *(1) for such month,* and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph [(1)] *(1) for such month* if it were equal to the excess of such wife's or husband's insurance benefit (before reduction under this subsection) over such old-age insurance benefit (before reduction under this subsection).

[(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's or husband's insurance benefit shall be reduced by the amount by which such benefit would be reduced under paragraph (1) if it were equal to the excess of such benefit (before reduction under this subsection) over such disability insurance benefit.]

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, or widow's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, or widow's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, or widow's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's [wife's or husband's] *wife's, husband's, or widow's* insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).

(E) If the first month for which an individual is entitled to an old-age insurance benefit (whether such first month occurs before, with, or after the month in which such individual attains the age of 65) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit to which such individual was first entitled for a month before she attained retirement age, then such old-age insurance benefit shall be reduced by whichever of the following is the larger:

(i) the amount by which (but for this subparagraph) such old-age insurance benefit would have been reduced under paragraph (1), or

(ii) the amount equal to the sum of the amount by which such widow's insurance benefit was reduced for the month in which such individual attained retirement age and the amount by which such old-age insurance benefit would be reduced under paragraph (1) if it were equal to the excess of such old-age insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection).

(F) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs with or after the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e) (1), be) entitled to a widow's insurance benefit to which such individual was first entitled for a month before she attained retirement age, then such disability insurance benefit for each month shall be reduced by whichever of the following is larger:

(i) the amount by which (but for this subparagraph) such disability insurance benefit would have been reduced under paragraph (2), or

(ii) the amount equal to the sum of the amount by which such widow's insurance benefit was reduced for the month in which such individual attained retirement age and the amount by which such disability insurance benefit would be reduced under paragraph (2) if it were equal to the excess of such disability insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection).

(G) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs before the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit, then such disability insurance benefit for each month shall be reduced by the amount such widow's insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained age 62 in the first month for which he most recently became entitled to a disability insurance benefit.

[(3)] *(4)* If—

(A) an individual is or was entitled to a benefit subject to reduction [under] *under paragraph (1) or (3) of* this subsection, and

(B) such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based,

then the amount of the reduction of such benefit for each month shall be computed separately (under paragraph (1) or [(2)] *(3)*, whichever applies) for the portion of such benefit which constitutes such benefit before any increase described in subparagraph (B), and separately (under paragraph (1) or [(2)] *(3)*, whichever applies to the benefit being increased) for each such increase. For purposes of determining the amount of the reduction under paragraph (1) or [(2)] *(3)* in any such increase, the reduction period and the adjusted reduction period shall be determined as if such increase were a separate benefit to which such individual was entitled for and after the first month for which such increase is effective.

[(4)] (5) (A) No wife's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by her with the Secretary, in accordance with regulations prescribed by him, in which she elects to receive wife's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which she has in her care (individually or jointly with the person on whose wages and self-employment income her wife's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A)(i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 203(c)(2))—

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the woman filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62, nor shall it be effective for any month to which subparagraph (A)(ii) applies.

(C) If a woman does not have in her care a child described in subparagraph (A)(ii) in the first month for which she is entitled to a wife's insurance benefit, and if such first month is a month before the month in which she attains age 65, she shall be deemed to have filed in such first month the certificate described in subparagraph (A)(i).

(D) No widow's insurance benefit for a month in which she has in her care a child of her deceased husband (or deceased former husband) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which she would have been entitled had she been entitled for such month to mother's insurance benefits on the basis of her deceased husband's (or deceased former husband's) wages and self-employment income.

[(5)] (6) For purposes of this subsection, the "reduction period" for an individual's old-age, [wife's or husband's] *wife's, husband's, or widow's* insurance benefit is the period—

(A) beginning—

(i) in the case of an old-age [or husband's], *husband's, or widow's* insurance benefit, with the first day of the first month for which such individual is entitled to such benefit, or

(ii) in the case of a wife's insurance benefit, with the first day of the first month for which a certificate described in paragraph (4)(A)(i) is effective, and

(B) ending with the last day of the month before the month in which such individual attains [age 65] *retirement age.*

[(6)] (7) For purposes of this subsection, the "adjusted reduction period" for an individual's old-age, [wife's, or husband's] *wife's, husband's, or widow's* insurance benefit is the reduction period prescribed by paragraph [(5)] (6) for such benefit, excluding from such period—

(A) any month in which such benefit was subject to deductions under section 203(b), 203(c)(1), 203(d)(1), or 222(b),

(B) in the case of wife's insurance benefits, any month in which she had in her care (individually or jointly with the person on

whose wages and self-employment income such benefit is based) a child of such person entitled to child's insurance benefits, [and]

(C) in the case of wife's or husband's insurance benefits, any month for which such individual was not entitled to such benefits because the spouse on whose wages and self-employment income such benefits were based ceased to be under a disability[.],

(D) in the case of widow's insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5)(D),

(E) in the case of widow's insurance benefits, any month before the month in which she attained retirement age for which she was not entitled to such benefit because of the occurrence of an event that terminated her entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

[(7)] *(8)* This subsection shall be applied after reduction under section 203(a) and after application of section 215(g). If the amount of any reduction computed under paragraph [(1)] *(1)*, *(2)*, or [(2)] *(3)* is not a multiple of $0.10, it shall be reduced to the next lower multiple of $0.10.

(9) For purposes of this subsection, the term "retirement age" means age 65 with respect to an old-age, wife's or husband's insurance benefit and age 62 with respect to a widow's insurance benefit.

Presumed Filing of Application by Individuals Eligible for Old-Age Insurance Benefits and for Wife's or Husband's Insurance Benefits

(r)(1) If the first month for which an individual is entitled to an old-age insurance benefit is a month before the month in which such individual attains age 65, and if such individual is eligible for a wife's or husband's insurance benefit for such first month, such individual shall be deemed to have filed an application in such month for wife's or husband's insurance benefits.

(2) If the first month for which an individual is entitled to a wife's or husband's insurance benefit reduced under subsection (q) is a month before the month in which such individual attains age 65, and if such individual is eligible *(but for section 202(k)(4))* for an old-age insurance benefit for such first month, such individual shall be deemed to have filed an application for old-age insurance benefits—

(A) in such month, or

(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit.

(3) For purposes of this subsection, an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, he would be entitled to such benefit for such month.

Child Aged 18 or Over Attending School

(s)(1) For the purposes of subsections (b)(1), (g)(1), (q)(5), and (q)(7) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 18 but is not in such month under a disability (as defined in section 223(c)), shall be deemed not entitled to

such benefits for such month, unless he was under such a disability in the third month before such month.

(2) Subsection (f)(4), and so much of subsections (b)(3), (d)(6), (e)(3), (g)(3), and (h)(4) of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 223(c)) which began before such child attained the age of 22 or had been under such a disability in the third month before the month in which such marriage occurred.

(3) Subsections (c)(2)(B) and (f)(2)(B) of this section, so much of subsections (b)(3), (d)(6), (e)(3), (g)(3), and (h)(4) of this section as follows the semicolon, the last sentence of subsection (c) of section 203, subsection (f)(1)(C) of section 203, and subsection (b)(3)(B), (c)(6)(B), (f)(3)(B), and (g)(6)(B) of section 216 shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 223(c)) which began before such child attained the age of 22.

Suspension of Benefits of Aliens Who Are Outside the United States

(t)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual who is not a citizen or national of the United States for any month which is—

(A) after the sixth consecutive calendar month during all of which the Secretary finds, on the basis of information furnished to him by the Attorney General or information which otherwise comes to his attention, that such individual is outside the United States; and

(B) prior to the first month thereafter for all of which such individual has been in the United States.

(2) Paragraph (1) shall not apply to any individual who is a citizen of a foreign country which the Secretary finds has in effect a social insurance or pension system which is of general application in such country and under which—

(A) periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, retirement, or death, and

(B) individuals who are citizens of the United States but not citizens of such foreign country and who qualify for such benefits are permitted to receive such benefits or the actuarial equivalent thereof while outside such foreign country without regard to the duration of the absence.

(3) Paragraph (1) shall not apply in any case where its application would be contrary to any treaty obligation of the United States in effect on the date of the enactment of this subsection.

(4) Paragraph (1) shall not apply to any benefit for any month if—

(A) not less than forty of the quarters elapsing before such month are quarters of coverage for the individual on whose wages and self-employment income such benefit is based, or

(B) the individual on whose wages and self-employment income such benefit is based has, before such month, resided in the United States for a period or periods aggregating ten years or more, or

(C) the individual entitled to such benefit is outside the United States while in the active military or naval service of the United States, or

(D) the individual on whose wages and self-employment income such benefit is based died, before such month, either (i) while on active duty or inactive duty training (as those terms are defined in section 210 (1) (2) and (3)) as a member of a uniformed service (as defined in section 210(m)), or (ii) as the result of a disease or injury which the Administrator of Veterans' Affairs determines was incurred or aggravated in line of duty while on active duty (as defined in section 210 (1) (2)), or an injury which he determines was incurred or aggravated in line of duty while on inactive duty training (as defined in section 210 (1) (3)), as a member of a uniformed service (as defined in section 210 (m)), if the Administrator determines that such individual was discharged or released from the period of such active duty or inactive duty training under conditions other than dishonorable, and if the Administrator certifies to the Secretary his determinations with respect to such individual under this clause, or

(E) the individual on whose employment such benefit is based had been in service covered by the Railroad Retirement Act which was treated as employment covered by this Act pursuant to the provisions of section 5(k)(1) of the Railroad Retirement Act.

(5) No person who is, or upon application would be, entitled to a monthly benefit under this section for December 1956 shall be deprived, by reason of paragraph (1), of such benefit or any other benefit based on the wages and self-employment income of the individual on whose wages and self-employment income such monthly benefit for December 1956 is based.

(6) If an individual is outside the United States when he dies and no benefit may, by reason of paragraph (1), be paid to him for the month preceding the month in which he dies, no lump-sum death payment may be made on the basis of such individual's wages and self-employment income.

(7) Subsections (b), (c), and (d) of section 203 shall not apply with respect to any individual for any month for which no monthly benefit may be paid to him by reason of paragraph (1) of this subsection.

(8) The Attorney General shall certify to the Secretary such information regarding aliens who depart from the United States to any foreign country (other than a foreign country which is territorially contiguous to the continental United States) as may be necessary to enable the Secretary to carry out the purposes of this subsection and shall otherwise aid, assist, and cooperate with the Secretary in obtaining such other information as may be necessary to enable the Secretary to carry out the purposes of this subsection.

(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).

Conviction of Subversive Activities, etc.

(u)(1) If any individual is convicted of any offense (committed after the date of the enactment of this subsection) 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,

then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 223 is payable to such individual for the month in which he is convicted or for any month thereafter, [and] in determining the amount of any such benefit payable to such individual for any such month, *and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month,* there shall not be taken into account—

(C) any wages paid to such individual or to any other individual in the calendar quarter in which such conviction occurs or in any prior calendar quarter, and

(D) any net earnings from self-employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1), been imposed with respect to any individual, the Attorney General shall notify the Secretary of such imposition.

(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted.

Waiver of Benefits

(v) Notwithstanding any other provisions of this title, in the case of any individual who files a waiver pursuant to section 1402(h) of the Internal Revenue Code of 1954 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver; except that, if thereafter such individual's tax exemption under such section 1402(h) ceases to be effective, such waiver shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on his self-employment income for and after the first taxable year for which such tax exemption ceases to be effective and on his wages for and after the calendar year (if any) which begins in or with the beginning of such taxable year.

Reduction of Insurance Benefits

Maximum Benefits

Sec. 203. (a) Whenever the total of monthly benefits to which individuals are entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an insured individual is greater than the amount appearing in column V of the table in section 215(a) on the line on which appears in column IV such insured individual's primary insurance amount, such total of benefits shall be reduced to such amounts; except that—

(1) when any of such individuals so entitled would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance

benefits on the basis of the wages and self-employment income of one or more other insured individuals, such total of benefits shall not be reduced to less than the smaller of: (A) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or (B) the last figure in column V of the table appearing in section 215(a), or

[(2) when any of such individuals was entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or section 223 for December 1958, and the primary insurance amount of the insured individual on the basis of whose wages and self-employment income such monthly benefits are payable is determined under the provisions of section 215(a)(2), then such total benefits shall not be reduced to less than the larger of—

[(A) the amount determined under this subsection without regard to this paragraph, or

[(B) the amount determined under this subsection as in effect prior to the enactment of the Social Security Amendments of 1958 or the amount determined under section 102(h) of the Social Security Amendments of 1954, as the case may be, plus the excess of—

[(i) the primary insurance amount of such insured individual in column IV of the table appearing in section 215(a), over

[(ii) his primary insurance amount determined under section 215(c), or

[(3) when any of such individuals is entitled (without the application of section 202(j)(l) and section 223(b)) to monthly benefits based on the wages and self-employment income of an insured individual with respect to whom a period of disability (as defined in section 216(i)) began prior to January 1959 and continued until—

[(A) he became entitled to benefits under section 202 or 223, or

[(B) he died, whichever first occurred,

and the primary insurance amount of such insured individual is determined under the provisions of section 215(a) (1) or (3), then such total of benefits shall not be reduced to less than $99.10 if such primary insurance amount is $66, to less than $102.40 if such primary insurance amount is $67, to less than $106.50 if such primary insurance amount is $68, or, if such primary insurance amount is higher than $68, to less than the smaller of—

[(C) the amount determined under this subsection without regard to this paragraph, or $206.60, whichever is larger, or

[(D) the amount in column V of such table on the same line on which, in column IV, appears his primary insurance amount, plus the excess of—

[(i) such primary insurance amount, over

[(ii) the smaller amount in column II of the table on the line on which appears such primary insurance amount.]

(2) when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under

section 202 or 223 for any month which begins after December 1964 and before the enactment of the Social Security Amendments of 1965, on the basis of the wages and self-employment income of such insured individual, such total of benefits for any month occurring after December 1964 shall not be reduced to less than the larger of—

(A) the amount determined under this subsection without regard to this paragraph, or

(B)(i) with respect to the month in which such Amendments are enacted or any prior month, an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of such Amendments, for each such person (other than a person who would not be entitled to such benefits for such month without the application of the amendments made by section 306 of the Social Security Amendments of 1965), for such month, by 107 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10, and

(ii) with respect to any month after the month in which such Amendments are enacted, an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of such Amendments, for each such person (other than a person who would not be entitled to such benefits for such month without the application of the amendments made by section 306 of the Social Security Amendments of 1965) for the month of enactment, by 107 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (I) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B) of this paragraph, and (II) if section 202(k)(2)(A) was applicable in the case of any of such benefits for any such month beginning before the enactment of the Social Security Amendments of 1965, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which such section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for such month beginning prior to such enactment [.], *or*

(3) when any of such individuals is entitled to monthly benefits as a divorced wife under section 202(b) or as a surviving divorced wife under section 202(e) for any month, the benefit to which she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced wife or surviving divorced wife were entitled to benefits for such month.

In any case in which benefits are reduced pursuant to the preceding provisions of this subsection, such reduction shall be made after any deductions under this section and after any deductions under section 222(b). Whenever a reduction is made under this subsection, each

benefit, except the old-age or disability insurance benefit, shall be proportionately decreased.

Deductions on Account of Work

(b) Deductions, in amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

(1) such individual's benefit or benefits under section 202 for any month, and

(2) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits of all other persons for such month under section 202 based on such individual's wages and self-employment income,

if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (1) and (2). If the excess earnings so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

(A) an individual shall be deemed to be entitled to payments under section 202 equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the penultimate sentence thereof; and

(B) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222(b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month.

Deductions on Account of Noncovered Work Outside the United States or Failure To Have Child in Care

(c) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total

of such deductions equals such individual's benefit or benefits under section 202 for any month—

(1) in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States; or

(2) in which such individual, if a wife under age sixty-five entitled to a wife's insurance benefit, did not have in her care (individually or jointly with her husband) a child of her husband entitled to a child's insurance benefit and such wife's insurance benefit for such month was not reduced under the provisions of section 202(q); or

(3) in which such individual, if a widow entitled to a mother's insurance benefit, did not have in her care a child of her deceased husband entitled to a child's insurance benefit; or

(4) in which such individual, if a [former wife divorced] *surviving divorced mother* entitled to a mother's insurance benefit, did not have in her care a child of her deceased former husband who (A) is her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of her deceased former husband.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit [for any month in which] *for any month in which paragraph (1) of section 202(s) applies or* an event specified in section 222(b) occurs with respect to such child. [No] *Subject to paragraph (3) of such section 202(s), no* deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month.

Deductions From Dependents' Benefits on Account of Noncovered Work Outside the United States by Old-Age Insurance Beneficiary

(d)(1) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits, to which a [wife,] *wife, divorced wife,* husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's insurance benefit to which a person is entitled, until that total of such deductions equals such child's insurance benefit or benefits or mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual who is entitled to old-age insurance benefits and on seven or more different calendar days of which such individual engaged in noncovered remunerative activity outside the United States.

Occurrence of More Than One Event

(e) If more than one of the events specified in subsections (c) and (d) and section 222(b) occurs in any one month which would occasion

deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

Months to Which Earnings Are Charged

(f) For purposes of subsection (b)—

(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits under section 202(a) and other persons are entitled to benefits under section 202 (b), (c), or (d) on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph, *but, subject to section 202(a)* no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was age seventy-two or over, (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, or (D) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than [$100] *$150*.

(2) As used in paragraph (1), the term "first month of such taxable year" means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), and (D) thereof.

(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be his earnings for such year in excess of the product of [$100] *$150* multiplied by the number of months in such year, except that of the first [$500] *$1,200* of such excess (or all of such excess if it is less than [$500] *$1,200*), an amount equal to one-half thereof shall not be included. The excess earnings as derived under the preceding sentence, if not a multiple of $1, shall be reduced to the next lower multiple of $1.

(4) For purposes of clause (D) of paragraph (1)—

(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Secretary that such individual rendered no substantial services in such

month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Secretary shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

(B) An individual will be presumed, with respect to any month, to have rendered service for wages (determined as provided in paragraph (5) of this subsection) of more than [$100] *$150* until it is shown to the satisfaction of the Secretary that such individual did not render such services in such month for more than such amount.

(5) (A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

[(B) In determining an individual's net earnings from self-employment and his net loss from self-employment for purposes of subparagraph (A) of this paragraph and paragraph (4), the provisions of section 211, other than paragraphs (1), (4), and (5) of subsection (c), shall be applicable; and any excess of income over deductions resulting from such a computation shall be his net earnings from self-employment and any excess of deductions over income so resulting shall be his net loss from self-employment.]

(B) For purposes of this section—

(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 211, except that paragraphs (1), (4), and (5) of section 211(c) shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D), and

(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(9) of the Internal Revenue Code of 1954) taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i).

(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209; and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment.

(D) In the case of an individual—

(i) who has attained the age of 65 on or before the last day of taxable year, and

(ii) who shows to the satisfaction of the Secretary that he is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he attained the age of 65 and

that the property to which the copyright or patent relates was created by his own personal efforts, there shall be excluded from gross income any such royalties.

(6) For purposes of this subsection, wages (determined as provided in paragraph (5)(C)) which, according to reports received by the Secretary, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Secretary that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Secretary that his taxable year is not a calendar year.

(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charting) to which all persons are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 202(k)(3), and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled.

Penalty for Failure To Report Certain Events

(g) Any individual in receipt of benefits subject to deduction under subsection (c) (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Secretary prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer an additional deduction equal to that imposed under subsection (c), except that the first additional deduction imposed by this subsection in the case of any individual shall not exceed an amount equal to one month's benefit even though the failure to report is with respect to more than one month.

Report of Earnings to Secretary

(h)(1)(A) If an individual is entitled to any monthly insurance benefit under section 202 during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (5) of subsection (f), in excess of the product of [$100] *$150* times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Secretary of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Secretary may by regulations prescribe. Such report need not be made for any taxable year (i) beginning with or after the month in which such individual attained the age of 72, or (ii) if benefit payments for all months (in such taxable year) in which

such individual is under age 72 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection.

(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year unless within such period the individual, or some other person entitled to benefits under this title on the basis of the same wages and self-employment income, files with the Secretary information showing that a benefit for such month is payable to such individual.

(2) If an individual fails to make a report required under paragraph (1), within the time prescribed therein, for any taxable year and any deduction is imposed under subsection (b) by reason of his earnings for such year, he shall suffer additional deductions as follows:

(A) if such failure is the first one with respect to which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

except that the number of the additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 202 and for which deductions are imposed under subsection (b) by reason of his earnings. In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

(3) If the Secretary determines, on the basis of information obtained by or submitted to him, that it may reasonably be expected that an individual entitled to benefits under section 202 for any taxable year will suffer deductions imposed under subsection (b) by reason of his earnings for such year, the Secretary may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Secretary may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Secretary has determined whether or not any deduction is imposed for such month under subsection (b). The Secretary is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make, at such time

or times as the Secretary may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Secretary such other information with respect to such earnings as the Secretary may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his earnings for such year. If, after the close of a taxable year of an individual entitled to benefits under section 202 for such year, the Secretary requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (5) of subsection (f)) for such taxable year or any other information with respect to such earnings which the Secretary may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for such months thereof as the Secretary may specify) by reason of his earnings for such year.

Circumstances Under Which Deductions and Reductions Not Required

(i) In the case of any individual, deductions by reason of the provisions of subsection (b), (c), (g), or (h) of this section, or the provisions of section 222(b), shall, notwithstanding such provisions, be made from the benefits to which such individual is entitled only to the extent that such deductions reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household.

Attainment of Age Seventy-two

(j) For the purposes of this section, an individual shall be considered as seventy-two years of age during the entire month in which he attains such age.

Noncovered Remunerative Activity Outside the United States

(k) An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 210 and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 211(a). When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee), the term "United States" does not include the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) and the term "trade or business" shall have the same meaning as when used in Section 162 of the Internal Revenue Code of 1954.

Good Cause for Failure To Make Reports Required

(l) The failure of an individual to make any report required by subsection (g) or (h) (l) (A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Secretary that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.

Overpayments and Underpayments

[**Sec. 204.** (a) Whenever an error has been made with respect to payments to an individual under this title (including payments made prior to January 1, 1940), proper adjustments shall be made, under regulations prescribed by the Secretary, by increasing or decreasing subsequent payments to which such individual is entitled. If such individual dies before such adjustment has been completed, adjustment shall be made by increasing or decreasing subsequent benefits payable with respect to the wages and self-employment income which were the basis of benefits of such deceased individual.]

Sec. 204. *(a) Whenever the Secretary finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, under regulations prescribed by the Secretary, as follows:*

(1) With respect to payment to a person of more than the correct amount the Secretary shall decrease any payment under this title to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this title payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall apply any combination of the foregoing.

(2) With respect to payment to a person of less than the correct amount, the Secretary shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made under regulations prescribed by the Secretary in such order of priority as he determines will best carry out the purposes of this title.

[(b) There shall be no adjustment or recovery by the United States in any case where incorrect payment has been made to an individual who is without fault (including payments made prior to January 1, 1940), and where adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience.]

(b) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience.

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

Evidence, Procedure, and Certification for Payment

Sec. 205. (a) The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b) The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Upon request by any such individual or upon request by a [wife, widow, former wife divorced] *wife, divorced wife, widow, surviving divorced wife, surviving divorced mother,* husband, widower, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered, he shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. Any such request with respect to such a decision must be filed within such period after such decision as may be prescribed in regulations of the Secretary, except that the period so prescribed may not be less than six months after notice of such decision is mailed to the individual making such request. The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

(c) (1) For the purposes of this subsection—

(A) The term "year" means a calendar year when used with respect to wages and a taxable year (as defined in section 211(e)) when used with respect to self-employment income.

(B) The term "time limitation" means a period of three years, three months, and fifteen days.

(C) The term "survivor" means an individual's spouse [former wife divorced,] *surviving divorced wife, surviving divorced mother,* child, or parent, who survives such individual.

(2) On the basis of information obtained by or submitted to the Secretary, and after such verification thereof as he deems necessary, the Secretary shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid and such income was derived, as shown by such records at the time of such request.

(3) The Secretary's records shall be evidence for the purpose of proceedings before the Secretary or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of

the periods in which such wages were paid and such income was derived. The absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Secretary may, if it is brought to his attention that any entry of wages or self-employment income in his records for such year is erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in his records, as the case may be. After the expiration of the time limitation following any year—

(A) the Secretary's records (with changes, if any, made pursuant to paragraph (5)) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this title;

(B) the absence of an entry in the Secretary's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this title that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Secretary's records as to the self-employment income alleged to have been derived by an individual in such year shall be conclusive for the purposes of this title that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of this self-employment income for such year before the expiration of the time limitation following such year, in which case the Secretary shall include in his records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Secretary may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Secretary's records of the wages paid to, or the self-employment income derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Secretary's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this title when they should have been credited under the Railroad Retirement Act, or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act when they should have been credited under this title;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform his records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act, under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, under chapter 2 or 21 of the Internal Revenue Code of 1954, or under regulations made under authority of such title, subchapter, or chapter;

(ii) wage reports filed by a State pursuant to an agreement under section 218 or regulations of the Secretary, thereunder; or

(iii) assessments of amounts due under an agreement pursuant to section 218, if such assessments are made within the period specified in subsection (q) of such section, or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Secretary's records pursuant to this subparagraph;

(G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Secretary;

(H) to include wages paid during any period in such year to an individual by an employer if there is an absence of an entry in the Secretary's records of wages having been paid by such employer to such individual in such period;

(I) to enter items which constitute remuneration for employment under subsection (o), such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k) (3) of the Railroad Retirement Act of 1937; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Secretary as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F)) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individ-

ual only if he has previously been notified by the Secretary of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose record is involved has previously been notified by the Secretary of the amount of such individual's wages and self-employment income for the period involved.

(7) Upon request in writing (within such period, after any change or refusal of a request for a change of his records pursuant to this subsection, as the Secretary may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual or his survivor. If a hearing is held pursuant to this paragraph the Secretary shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in his records as may be required by such findings and decision.

(8) Decisions of the Secretary under this subsection shall be reviewable by commencing a civil action in the United States district court as provided in subsection (g).

(d) For the purpose of any hearing, investigation, or other proceeding authorized or directed under this title, or relative to any other matter within his jurisdiction hereunder, the Secretary shall have power to issue subpenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Secretary. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpenas of the Secretary shall be served by anyone authorized by him (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Secretary, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

(f) No person so subpenaed or ordered shall be excused from attending and testifying or from producing books, records, correspondence, documents, or other evidence on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture; but no person shall be prosecuted or subjected to any penalty or forfeiture for, or on account of, any transaction, matter, or thing concerning which he is compelled, after having claimed his privilege against self-incrimination, to testify or produce evidence, except that such person so testifying shall not be exempt

from prosecution and punishment for perjury committed in so testifying.

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or his decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(h) The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 24 of the Judicial Code of the United States to recover on any claim arising under this title.

(i) Upon final decision of the Secretary, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this title, the Secretary shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or

payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Treasury Department, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary: *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

(j) When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person.

(k) Any payment made after December 31, 1939, under conditions set forth in subsection (j), any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Secretary of incompetency prior to certification of payment, if otherwise valid under this title, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health, Education, and Welfare designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e).

[(n) The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals.]

(n) The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 204(a) with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this title for such month.

Crediting of Compensation Under the Railroad Retirement Act

(o) If there is no person who would be entitled, upon application therefor, to an annuity under section 5 of the Railroad Retirement Act of 1937, or to a lump-sum payment under subsection(f)(1) of such section, with respect to the death of an employee (as defined in such Act), then notwithstanding section 210(a)(9) of this Act, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 4 of such Act if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 217 of this Act) of such

employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this title on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this title, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

Special Rules in Case of Federal Service

(p) (1) With respect to service included as employment under section 210 which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (l)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 210(o) are applicable, the Secretary shall not make determinations as to whether an individual has performed such service, the periods of such service, the amounts of remuneration for such service which constitute wages under the provisions of section 209, or the periods in which or for which such wages were paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954 and certifications made pursuant to this subsection. Such determinations shall be final and conclusive.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Secretary, to make certification to him with respect to any matter determinable for the Secretary by such head or his agents under this subsection, which the Secretary finds necessary in administering this title.

(3) The provisions of paragraphs (1) and (2) shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the confort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;

and for purposes of paragraphs (1) and (2) the Secretary of the Treasury shall be deemed to be the head of such instrumentality.

[Representation of Claimants Before the Secretary]

Sec. 206(*a*). The Secretary may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Secretary, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimant valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Secretary. The Secretary may, after due notice and opportunity for hearing, suspend or prohibit from further practice before him any such person, agent, or attorney who refuses to comply with the Secretary's rules and regulations or who violates any provision of this secton for which a penalty is prescribed. The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Secretary under this title, and any agreement in violation of such rules and regulations shall be void. Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter, or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Secretary shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both.

(b)(1) Whenever a court renders a judgment favorable to a claimant who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past due benefits to which the claimant is entitled by reason of such judgment, and the Secretary may, notwithstanding the provisions of section (i), 205 certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.

Assignment

Sec. 207. The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

Penalties

Sec. 208. Whoever—

(a) for the purpose of causing an increase in any payment authorized to be made under this title, or for the purpose of causing any payment to be made where no payment is authorized under this title, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939, or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954) as to—

(1) whether wages were paid or received for employment (as said terms are defined in this title and the Internal Revenue Code), or the amount of wages or the period during which paid or the person to whom paid; or

(2) whether net earnings from self-employment (as such term is defined in this title and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(3) whether a person entitled to benefits under this title had earnings in or for a particular period (as determined under section 203(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(b) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or

(c) at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title; or

(d) having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this title, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

(e) having made application to receive payment under this title for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person;

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

Definition of Wages

Sec. 209. For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(a)(1) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $3,600 with respect to employment has been paid to an individual during any calendar year prior to 1955, is paid to such individual during such calendar year;

(2) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,200 with respect to employment has been paid to an individual during any calendar year after 1954 and prior to 1959, is paid to such individual during such calendar year;

(3) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,800 with respect to employment has been paid to an individual during any calendar year after 1958, *and prior to 1966* is paid to such individual during such calendar year;

(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,600 with respect to employment has been paid to an individual during any calendar year after 1965, is paid to such individual during such calendar year;

(b) The amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of (1) retirement, or (2) sickness or accident disability, or (3) medical or hospitalization expenses in connection with sickness or accident disability, or (4) death;

(c) Any payment made to an employee (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement;

(d) Any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of six calendar months following the last calendar month in which the employee worked for such employer;

(e) Any payment made to, or on behalf of, an employee or his beneficiary (1) from or to a trust exempt from tax under section 165 (a) of the Internal Revenue Code of 1939 at the time

of such payment or, in the case of a payment after 1954, under sections 401 and 501(a) of the Internal Revenue Code of 1954, unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or (2) under or to an annuity plan which, at the time of such payment, meets the requirements of section 165(a) (3), (4), (5), and (6) of the Internal Revenue Code of 1939 or, in the case of a payment after 1954 and prior to 1963, the requirements of section 401(a) (3), (4), (5), and (6) of the Internal Revenue Code of 1954, or (3) under or to an annuity plan which, at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1954, or (4) under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954;

(f) The payment by an employer (without deduction from the remuneration of the employee) (1) of the tax imposed upon an employee under section 1400 of the Internal Revenue Code of 1939, or in the case of a payment after 1954 under section 3101 of the Internal Revenue Code of 1954, or (2) of any payment required from an employee under a State unemployment compensation law;

(g)(1) Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(2) Cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this paragraph, the term "domestic service in a private home of the employer" does not include service described in section 210(f)(5);

(3) Cash remuneration paid by an employer in any calendar quarter to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this paragraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in section 210(f)(5);

(h)(1) Remuneration paid in any medium other than cash for agricultural labor;

(2) Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (A) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or (B) the employee performs agricultural labor for the employer on twenty days or more during such year for cash remuneration computed on a time basis;

(i) Any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62 (if a woman) or age 65 (if a man), if he did not work for the employer in the period for which such payment is made. As used in this subsection, the term "sick pay" includes remuneration for serv-

ice in the employ of a State, a political subdivision (as defined in section 218(b)(2)) of a State, or an instrumentality of two or more States, paid to an employee thereof for a period during which he was absent from work because of sickness;

(j) Remuneration paid by an employer in any quarter to an employee for service described in section 210(j)(3)(C) (relating to home workers), if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50; or

(k) Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1954.

For purposes of this title, in the case of domestic service described in subsection (g)(2), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this title, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (g)(2).

For purposes of this title, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, the term "wages" shall, subject to the provisions of subection (a) of this section, include as such individual's remuneration for such service only his basic pay as described in section 102(10) of the Servicemen's and Veterans' Survivor Benefits Act.

For purposes of this title, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 210(o) are applicable, (1) the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only amounts certified as payable pursuant to section 5(c) or 6(1) of the Peace Corps Act, and (2) any such amount shall be deemed to have been paid to such individual at the time the service, with respect to which it is paid, is performed.

Definition of Employment

Sec. 210. For the purposes of this title—

Employment

(a) The term "employment" means any service performed after 1936 and prior to 1951 which was employment for the purposes of this title under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1950 either (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American

aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen of the United States as an employee (i) of an American employer (as defined in subsection (e)), or (ii) of a foreign subsidiary (as defined in section 3121(l) of the Internal Revenue Code of 1954) of a domestic corporation (as determined in accordance with section 7701 of the Internal Revenue Code of 1954) during any period for which there is in effect an agreement, entered into pursuant to section 3121(l) of the Internal Revenue Code of 1954, with respect to such subsidiary; except that, in the case of service performed after 1950, such term shall not include—

(1) Service performed by foreign agricultural workers (A) under contracts entered into in accordance with title V of the Agricultural Act of 1949, as amended, or (B) lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) Domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3) (A) Service performed by an individual in the employ of his spouse, and service performed by a child under the age of twenty-one in the employ of his father or mother;

(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter;

(4) Service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) Service performed in the employ of any instrumentality of the United States, if such instrumentality is exempt from the tax imposed by section 3111 of the Internal Revenue Code of 1954 by virtue of any provisions of law which specifically refers to such section in granting such exemption;

(6) (A) Service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is covered by a retirement system established by a law of the United States;

(B) Service performed by an individual in the employ of an instrumentality of the United States if such an instrumentality was exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939 on December 31, 1950, and if such service is covered by a retirement system established by such instrumentality; except that the provisions of this subparagraph shall not be applicable to—

(i) service performed in the employ of a corporation which is wholly owned by the United States;

(ii) service performed in the employ of a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Home Loan Bank, or a Federal Credit Union;

(iii) service performed in the employ of a State, county, or community committee under the Production and Marketing Administration;

(iv) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; or

(v) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;

(C) Service performed in the employ of the United States or in the employ of any instrumentality of the United States if such service is performed—

(i) as the President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress;

(ii) in the legislative branch;

(iii) in a penal institution of the United States by an inmate thereof;

(iv) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government; 5 U.S.C., sec. 1052), *other than as a medical or dental intern or a medical or dental resident in training;*

(v) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

(vi) by any individual to whom the Civil Service Retirement Act does not apply because such individual is subject to another retirement system (other than the retirement system of the Tennessee Valley Authority);

(7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service included under an agreement under section 218,

(B) service which, under subsection (k), constitutes covered transportation service, [or]

(C) service in the employ of the Government of Guam or the Goverment of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever, is appropriate[;], or

(D) Service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government; 5 U.S.C. 1052), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis;

(8) (A) Service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(B) Service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) of the Internal Revenue Code of 1954, which is exempt from income tax under section 501(a) of such Code, but this subparagraph shall not apply to service performed during the period for which a certificate, filed pursuant to section 3121(k) of the Internal Revenue Code of 1954, is in effect if such service is performed by an employee—

(i) whose signature appears on the list filed by such organization under such section 3121(k),

(ii) who became an employee of such organization after the calendar quarter in which the certificate (other than a certificate referred to in clause (iii) was filed, or

(iii) who, after the calendar quarter in which the certificate was filed with respect to a group described in paragraph (1) (E) of such section 3121(k), became a member of such group, except that this subparagraph shall apply with respect to service performed by an employee as a member of a group described in such paragraph (1)(E) with respect to which no certificate is in effect;

(9) Service performed by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954;

(10) (A) Service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501 of the Internal Revenue Code of 1954, if the remuneration for such service is less than $50;

(B) Service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university;

(11) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) Service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) Service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law; [and service performed as an interne in the employ of a hospital by an individual who has completed a four years' course in a medical school chartered or approved pursuant to State law]

(14) (A) Service performed by an individual under the age of eighteen in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) Service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) Service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and im-

munities as an international organization under the International Organizations Immunities Act (59 Stat. 669);

(16) Service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) Service in the employ of any organization which is performed (A) in any quarter during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after Jun 30, 1956;

(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)); or

(19) Service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be.

Included and Excluded Service

(b) If the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (9) of subsection (a).

American Vessel

(c) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign

country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

American Aircraft

(d) The term "American aircraft" means an aircraft registered under the laws of the United States.

American Employer

(e) The term "American employer" means an employer which is (1) the United States or any instrumentality thereof, (2) a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing, (3) an individual who is a resident of the United States, (4) a partnership, if two-thirds or more of the partners are residents of the United States, (5) a trust, if all of the trustees are residents of the United States, or (6) a corporation organized under the laws of the United States or of any State.

Agricultural Labor

(f) The term "agricultural labor" includes all service performed—

(1) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife.

(2) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm.

(3) In connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15 (g) of the Agricultural Marketing Act, as amended, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes.

(4) (A) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed.

(B) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For the purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than twenty at

any time during the calendar quarter in which such service is performed.

(5) On a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

The provisions of subparagraphs (A) and (B) of paragraph (4) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption.

Farm

(g) The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

State

(h) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(i) The term "United States" when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Employee

(j) The term "employee" means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2) of this subsection) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or drycleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other

similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

Covered Transportation Service

(k) (1) Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system is, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision

prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) For the purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this title, and some of such employees become employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of (i) a State, (ii) one or more political subdivisions of a State, or (iii) a State and one or more of its political subdivisions.

Service in the Uniformed Services

(l)(1) Except as provided in paragraph (4), the term "employment" shall, notwithstanding the provisions of subsection (a) of this section, include service performed after December 1956 by an individual as a member of a uniformed service on active duty; but such term shall not include any such service which is performed while on leave without pay.

(2) The term "active duty" means "active duty" as described in section 102 of the Servicemen's and Veterans' Survivor Benefits Act, except that it shall also include "active duty for training" as described in such section.

(3) The term "inactive duty training" means "inactive duty training" as described in such section 102.

(4) (A) Paragraph (1) of this subsection shall not apply in the case of any service, performed by an individual as a member of a uniformed service, which is creditable under section 4 of the Railroad Retirement Act of 1937. The Railroad Retirement Board shall notify the Secretary of Health, Education, and Welfare, as provided in section 4(p)(2) of that Act, with respect to all such service which is so creditable.

(B) In any case where benefits under this title are already payable on the basis of such individual's wages and self-employment income at the time such notification (with respect to such individual) is received by the Secretary, the Secretary shall certify no further benefits for payment under this title on the basis of such individual's wages and self-employment income, or shall recompute the amount of any further benefits payable on the basis of such wages and self-employment income, as may be required as a consequence of subparagraph (A) of this paragraph. No payment of a benefit to any person on the basis of such individual's wages and self-employment income, certified by the

Secretary prior to the end of the month in which he receives such notification from the Railroad Retirement Board, shall be deemed by reason of this subparagraph to have been an erroneous payment or a payment to which such person was not entitled. The Secretary shall, as soon as possible after the receipt of such notification from the Railroad Retirement Board, advise such Board whether or not any such benefit will be reduced or terminated by reason of subparagraph (A), and if any such benefit will be so reduced or terminated, specify the first month with respect to which such reduction or termination will be effective.

Member of a Uniformed Service

(m) The term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component of a uniformed service as defined in section 102(3) of the Servicemen's and Veterans' Survivor Benefits Act), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military or naval service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Universal Military Training and Service Act, has been selected for active military or naval service; and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

Crew Leader

(n) The term "crew leader" means an individual who furnishes dndividuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and service

performed as a member of the crew, be deemed not to be an employee of such other person.

Peace Corps Volunteer Service

(o) The term "employment" shall, notwithstanding the provisions of subsection (a), include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act.

Self-Employment

Sec. 211. For the purposes of this title—

Net Earnings From Self-Employment

(a) The term "net earnings from self-employment" means the gross income, as computed under Subtitle A of the Internal Revenue Code of 1954, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of income or loss described in section 702(a)(9) of the Internal Revenue Code of 1954, from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary income or loss—

(1) There shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares), together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant with respect to any such agricultural or horticultural commodity;

(2) There shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest (other than interest described in section 35 of the Internal Revenue Code of 1954) are received in the course of a trade or business as a dealer in stocks or securities;

(3) There shall be excluded any gain or loss (A) which is considered under Subtitle A of the Internal Revenue Code of 1954 as gain or loss from the sale or exchange of a capital asset, (B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 of the Internal Revenue Code of 1954 applies to

such gain or loss, or (C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither (i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor (ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) The deduction for net operating losses provided in section 172 of such Code shall not be allowed;

(5) (A) If any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife;

(B) If any portion of a partner's distributive share of the ordinary net income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1954;

(7) An individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages) and section 119 (relating to meals and lodging furnished for the convenience of the employer) of the Internal Revenue Code of 1954 and, in addition, if he is a citizen of the United States performing such service as an employee of an American employer (as defined in section 210(e)) or as a minister in a foreign country who has a congregation which is composed predominantly of citizens of the United States, without regard to section 911 (relating to earned income from sources without the United States) and section 931 (relating to income from sources within possessions of the United States) of such Code; and

(8) The term "possession of the United States" as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) of the Internal Revenue Code of 1954 shall be deemed not to include the Virgin Islands, Guam, or American Samoa.

If the taxable year of a partner is different from that of the partnership the distributive share which he is required to include in computing his net earnings from self-employment shall be based upon the ordinary net income or loss of the partnership for any taxable year of the partner-

ship (even though beginning prior to 1951) ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 210(f)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than [$1,800] *$2,400* the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66⅔ percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than [$1,800] *$2,400* and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than [$1,200] *$1,600*, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be [$1,200] *$1,600*, and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payment to which section 707(c) of the Internal Revenue Code of 1954 applies) is not more than [$1,800] *$2,400*, his distributive share of income described in section 702(a)(9) of such Code derived from such trade or business may, at his option, be deemed to be an amount equal to 66⅔ percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1954 applies) is more than [$1,800] *$2,400*, and his distributive share (whether or not distributed) of income described in section 702(a)(9) of such Code derived from such trade or business (computed under this subsection without regard to this sentence) is less than [$1,200] *$1,600* his distributive share of income described in such section 702(a)(9) derived from such trade or business may, at his option, be deemed to be [$1,200] *$1,600*

For the purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one

such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

Self-Employment Income

(b) The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual) during any taxable year beginning after 1950; except that such term shall not include—

(1) That part of the net earnings from self-employment which is in excess of—

(A) For any taxable year ending prior to 1955, (i) $3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) For any taxable year ending after 1954 and prior to 1959, (i) $4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) For any taxable year ending after 1958 *and prior to 1966*, (i) $4,800, minus (ii) the amount of the wages paid to such individual during the taxable year[; or] *; and*

(D) For any taxable year ending after 1965 (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; or

(2) The net earnings from self-employment, if such net earnings for the taxable year are less than $400.

An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purposes of this subsection, be considered to be a nonresident alien individual.

Trade or Business

(c) The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954, except that such terms shall not include—

(1) The performance of the functions of a public office;

(2) The performance of service by an individual as an employee, other than—

(A) service described in section 201(a)(14)(B) performed by an individual who has attained the age of eighteen,

(B) service described in section 210(a)(16),

(C) service described in section 210(a)(11), (12), or (15) performed in the United States by a citizen of the United States, and

(D) service described in paragraph (4) of this subsection;

(3) The performance of service by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954:

(4) The performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order; [or]

[(5) The performance of service by an individual in the exercise of his profession as a doctor of medicine or Christian Science practitioner; or the performance of such service by a partnership.]

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner [.]; *or*

(6) The performance of service by an individual during the period for which an exemption under section 1402(h) of the Internal Revenue Code of 1954 is effective with respect to him.

[The provisions of paragraph (4) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by such individual under section 1402(e) of the Internal Revenue Code of 1954 is in effect. The provisions of paragraph (5) shall not apply to service performed by an individual in the exercise of his profession as a Christian Science practitioner during the period for which a certificate filed by him under section 1402(e) of the Internal Revenue Code of 1954 is in effect.] *The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under section 1402(e) of the Internal Revenue Code of 1954 is in effect. The provisions of paragraph (2) shall not have the effect of excluding cash tips received by an employee in the course of service which constitutes employment under this title, on his own behalf and not on behalf of another person, from "net earnings from self-employment" except that (i) this sentence shall not apply in the case of tips which constitute remuneration for employment under this title, and (ii) in applying subsection (a) with respect to tips to which this sentence is applicable, only the deductions attributable to such tips shall be taken into account.*

Partnership and Partner

(d) The term "partnership" and the term "partner" shall have the same meaning as when used in subchapter K of chapter 1 of the Internal Reveue Code of 1954.

Taxable Year

(e) The term "taxable year" shall have the same meaning as when used in subtitle A of the Internal Revenue Code of 1954; and the taxable year of any individual shall be a calendar year unless he has a different taxable year for the purposes of subtitle A of such Code, in which case his taxable year for the purposes of this title shall be the same as his taxable year under such subtitle A.

Partner's Taxable Year Ending as Result of Death

(f) In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which

is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

Crediting of Self-Employment Income to Calendar Quarters

Sec. 212. For the purposes of determining average monthly wage and quarters of coverage the amount of self-employment income derived during any taxable year shall be credited to calendar quarters as follows:

(a) In the case of a taxable year which is a calendar year the self-employment income of such taxable year shall be credited equally to each quarter of such calendar year.

(b) In the case of any other taxable year the self-employment income shall be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

Quarter and Quarter of Coverage

Definitions

Sec. 213. (a) For the purpose of this title—

(1) The term "quarter", and the term "calendar quarter", means a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(2) The term "quarter of coverage" means a quarter in which the individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with $100 or more of self-employment income, except that—

(i) no quarter after the quarter in which such individual died shall be a quarter of coverage, and no quarter any part of which was included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

(ii) if the wages paid to any individual in any calendar year equal $3,000 in the case of a calendar year before 1951, or $3,600 in the case of a calendar year after 1950 and before 1955, or $4,200 in the case of a calendar year after 1954 and before 1959, or $4,800 in the case of a calendar year [after 1958] *after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965*, each quarter of such year shall (subject to clause (i)) be a quarter of coverage;

(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals $3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or $4,200 in the case of a taxable year ending after 1954 and before 1959, or $4,800 in the case of a taxable year ending [after 1958] *after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965*, each quarter any part of which falls

in such year shall (subject to clause (i)) be a quarter of coverage;

(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954, then, subject to clause (i), (a) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed $100 but are less than $200; (b) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $200 but are less than $300; (c) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $300 but are less than $400; and (d) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are $400 or more; and

(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter.

If, in the case of any individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954, the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 214(a) (3) are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.

Crediting of Wages Paid in 1937

(b) With respect to wages paid to an individual in the six-month periods commencing either January 1, 1937, or July 1, 1937; (A) if wages of not less than $100 were paid in any such period, one-half of the total amount thereof shall be deemed to have been paid in each of the calendar quarters in such period; and (B) if wages of less than $100 were paid in any such period, the total amount thereof shall be deemed

to have been paid in the latter quarter of such period, except that if in any such period, the individual attained age sixty-five, all of the wages paid in such period shall be deemed to have been paid before such age was attained.

Insured Status for Purposes of Old-Age and Survivors Insurance Benefits

Sec. 214. For the purposes of this title—

Fully Insured Individual

(a) The term "fully insured individual" means any individual who had not less than—

(1) one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or, if later, the year in which he attained age 21) and before—

(A) in the case of a woman, the year in which she died or (if earlier) the year in which she attained age 62,

(B) in the case of a man who has died, the year in which he died or (if earlier) the year in which he attained age 65, or

(C) In the case of a man who has not died, the year in which he attained (or would attain) age 65,

except that in no case shall an individual be a fully insured individual unless he has at least 6 quarters of coverage; or

(2) 40 quarters of coverage; or

(3) in the case of an individual who died before 1951, 6 quarters of coverage;

not counting as an elapsed year for purposes of paragraph (1) any year any part of which was included in a period of disability (as defined in section 216 (i)).

Currently Insured Individual

(b) The term "currently insured individual" means any individual who has not less than six quarters of coverage during the thirteen-quarter period ending with (1) the quarter in which he died, (2) the the quarter in which he became entitled to old-age insurance benefits, (3) the quarter in which he became entitled to primary insurance benefits under this title as in effect prior to the enactment of this section, or (4) in the case of any individual entitled to disability insurance benefits, the quarter in which he most recently became entitled to disability insurance benefits, not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage.

Computation of Primary Insurance Amount

Sec. 215. For the purposes of this title—

(a) Subject to the conditions specified in subsections (b), (c), and (d) of this section, the primary insurance amount of an insured individual shall be whichever of the following is the largest:

(1) The amount in column IV on the line on which in column III of the following table appears his average monthly wage (as determined under subsection (b));

(2) The amount in column IV on the line on which in column II of the following table appears his primary insurance amount (as determined under subsection (c));

(3) The amount in column IV on the line on which in column I of the following table appears his primary insurance benefit (as determined under subsection (d)); or

[(4) In the case of—

[(A) a woman who was entitled to a disability insurance benefit for the month before the month in which she died or became entitled to old-age insurance benefits, or

[(B) a man who was entitled to a disability insurance benefit for the month before the month in which he died or attained age 65,]

(4) In the case of an individual who was entitled to a disability insurance benefit for the month before the month in which he died, became entitled to old-age insurance benefits, or attained age 65, the amount in column IV which is equal to [such disability insurance benefit] *the primary insurance amount upon which such disability insurance benefit is based.*

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1954 Act)		III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—		Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred t in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—	At least—	But not more than—	At least—	But not more than—		
----------	$13.48	----------	$37.00	----------	$67	$40	$60.00
$13.49	14.00	$37.10	38.00	$68	69	41	61.50
14.01	14.48	38.10	39.00	70	70	42	63.00
14.49	15.00	39.10	40.00	71	72	43	64.50
15.01	15.60	40.10	41.00	73	74	44	66.00
15.61	16.20	41.10	42.00	75	76	45	67.50
16.21	16.84	42.10	43.00	77	78	46	69.00
16.85	17.60	43.10	44.00	79	80	47	70.50
17.61	18.40	44.10	45.00	81	81	48	72.00
18.41	19.24	45.10	46.00	82	83	49	73.50
19.25	20.00	46.10	47.00	84	85	50	75.00
20.01	20.64	47.10	48.00	86	87	51	76.50
20.65	21.28	48.10	49.00	88	89	52	78.00
21.29	21.88	49.10	50.00	90	90	53	79.50
21.89	22.28	50.10	50.90	91	92	54	81.00
22.29	22.68	51.00	51.80	93	94	55	82.50
22.69	23.08	51.90	52.80	95	96	56	84.00
23.09	23.44	52.90	53.70	97	97	57	85.50
23.45	23.76	53.80	54.60	98	99	58	87.00
23.77	24.20	54.70	55.60	100	101	59	88.50
24.21	24.60	55.70	56.50	102	102	60	90.00
24.61	25.00	56.60	57.40	103	104	61	91.50
25.01	25.48	57.50	58.40	105	106	62	93.00
25.49	25.92	58.50	59.30	107	107	63	94.50
25.93	26.40	59.40	60.20	108	109	64	96.00
26.41	26.94	60.30	61.20	110	113	65	97.50
26.95	27.46	61.30	62.10	114	118	66	99.00
27.47	28.00	62.20	63.00	119	122	67	100.50
28.01	28.68	63.10	64.00	123	127	68	102.00
28.69	29.25	64.10	64.90	128	132	69	105.60
29.26	29.68	65.00	65.80	133	136	70	108.80
29.69	30.36	65.90	66.80	137	141	71	112.80
30.37	30.92	66.90	67.70	142	146	72	116.80

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1954 Act)		III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—		Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—	At least—	But not more than—	At least—	But not more than—		
$30.93	$31.36	$67.80	$68.60	$147	$150	$73	$120.00
31.37	32.00	68.70	69.60	151	155	74	124.00
32.01	32.60	69.70	70.50	156	160	75	128.00
32.61	33.20	70.60	71.40	161	164	76	131.20
33.21	33.88	71.50	72.40	165	169	77	135.20
33.89	34.50	72.50	73.30	170	174	78	139.20
34.51	35.00	73.40	74.20	175	178	79	142.40
35.01	35.80	74.30	75.20	179	183	80	146.40
35.81	36.40	75.30	76.10	184	188	81	150.40
36.41	37.08	76.20	77.10	189	193	82	154.40
37.09	37.60	77.20	78.00	194	197	83	157.60
37.61	38.20	78.10	78.90	198	202	84	161.60
38.21	39.12	79.00	79.90	203	207	85	165.60
39.13	39.68	80.00	80.80	208	211	86	168.80
39.69	40.33	80.90	81.70	212	216	87	172.80
40.34	41.12	81.80	82.70	217	221	88	176.80
41.13	41.76	82.80	83.60	222	225	89	180.00
41.77	42.44	83.70	84.50	226	230	90	184.00
42.45	43.20	84.60	85.50	231	235	91	188.00
43.21	43.76	85.60	86.40	236	239	92	191.20
43.77	44.44	86.50	87.30	240	244	93	195.20
44.45	44.88	87.40	88.30	245	249	94	199.20
44.89	45.60	88.40	89.20	250	253	95	202.40
		89.30	90.10	254	258	96	206.40
		90.20	91.10	259	263	97	210.40
		91.20	92.00	264	267	98	213.60
		92.10	92.90	268	272	99	217.60
		93.00	93.90	273	277	100	221.60
		94.00	94.80	278	281	101	224.80
		94.90	95.80	282	286	102	228.80
		95.90	96.70	287	291	103	232.80
		96.80	97.60	292	295	104	236.00
		97.70	98.60	296	300	105	240.00
		98.70	99.50	301	305	106	244.00
		99.60	100.40	306	309	107	247.20
		100.50	101.40	310	314	108	251.20
		101.50	102.30	315	319	109	254.00
		102.40	103.20	320	323	110	254.00
		103.30	104.20	324	328	111	254.00
		104.30	105.10	329	333	112	254.00
		105.20	106.00	334	337	113	254.00
		106.10	107.00	338	342	114	254.00
		107.10	107.90	343	347	115	254.00
		108.00	108.50	348	351	116	254.00
				352	356	117	254.00
				357	361	118	254.00
				362	365	119	254.00
				366	370	120	254.00
				371	375	121	254.00
				376	379	122	254.00
				380	384	123	254.00
				385	389	124	254.00
				390	393	125	254.00
				394	398	126	254.00
				399	400	127	254.00

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1958 Act, as modified)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203 (a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
----------	$13.48	$40	----------	$67	$44.00	$66.00
$13.49	14.00	41	$68	69	45.00	67.50
14.01	14.48	42	70	70	46.00	69.00
14.49	15.00	43	71	72	47.00	70.50
15.01	15.60	44	73	74	48.00	72.00
15.61	16.20	45	75	76	49.00	73.50
16.21	16.84	46	77	78	50.00	75.00
16.85	17.60	47	79	80	51.00	76.50
17.61	18.40	48	81	81	52.00	78.00
18.41	19.24	49	82	83	53.00	79.50
19.25	20.00	50	84	85	54.00	81.00
20.01	20.64	51	86	87	55.00	82.50
20.65	21.28	52	88	89	56.00	84.00
21.29	21.88	53	90	90	57.00	85.50
21.89	22.28	54	91	92	58.00	87.00
22.29	22.68	55	93	94	59.00	88.50
22.69	23.08	56	95	96	60.00	90.00
23.09	23.44	57	97	97	61.00	91.50
23.45	23.76	58	98	99	62.10	93.20
23.77	24.20	59	100	101	63.20	94.80
24.21	24.60	60	102	102	64.20	96.30
24.61	25.00	61	103	104	65.30	98.00
25.01	25.48	62	105	106	66.40	99.60
25.49	25.92	63	107	107	67.50	101.30
25.93	26.40	64	108	109	68.50	102.80
26.41	26.94	65	110	113	69.60	104.40
26.95	27.46	66	114	118	70.70	106.10
27.47	28.00	67	119	122	71.70	107.60
28.01	28.68	68	123	127	72.80	109.20
28.09	29.25	69	128	132	73.90	110.90
29.26	29.68	70	133	136	74.90	112.40
29.69	30.36	71	137	141	76.00	114.00
30.37	30.92	72	142	146	77.10	116.80
30.93	31.36	73	147	150	78.20	120.00
31.37	32.00	74	151	155	79.20	124.00
32.01	32.60	75	156	160	80.30	128.00
32.61	33.20	76	161	164	81.40	131.20
33.21	33.88	77	165	169	82.40	135.20
33.89	34.50	78	170	174	83.50	139.20
34.51	35.00	79	175	178	84.60	142.40
35.01	35.80	80	179	183	85.60	146.40
35.81	36.40	81	184	188	86.70	150.40
36.41	37.08	82	189	193	87.80	154.40
37.09	37.60	83	194	197	88.90	157.60
37.61	38.20	84	198	202	89.90	161.60
38.21	39.12	85	203	207	91.00	165.60
39.13	39.68	86	208	211	92.10	168.80
39.69	40.33	87	212	216	93.10	172.80
40.34	41.12	88	217	221	94.20	176.80
41.13	41.76	89	222	225	95.30	180.00
41.77	42.44	90	226	230	96.30	184.00
42.45	43.20	91	231	235	97.40	188.00
43.21	43.76	92	236	239	98.50	191.20
43.77	44.44	93	240	244	99.60	195.20
44.45	44.88	94	245	249	100.60	199.20
44.89	45.60	95	250	253	101.70	202.40
		96	254	258	102.80	206.40
		97	259	263	105.80	210.40
		98	264	267	104.90	213.60
		99	268	272	106.00	217.60
		100	273	277	107.00	221.60
		101	278	281	108.10	224.80
		102	282	286	109.20	228.80
		103	287	291	110.30	232.80

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		*(Primary insurance amount under 1958 Act, as modified)*	*(Average monthly wage)*		*(Primary insurance amount)*	*(Maximum family benefits)*
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		*Or his primary insurance amount (as determined under subsec. (c)) is—*	*Or his average monthly wage (as determined under subsec. (b)) is—*		*The amount referred to in the preceding paragraphs of this subsection shall be—*	*And the maximum amount of benefits payable (as provided in sec. 203 (a)) on the basis of his wages and self-employment income shall be—*
At least—	*But not more than—*		*At least—*	*But not more than—*		
		$104	$292	$295	$111.30	$236.00
		105	296	300	112.40	240.00
		106	301	305	113.50	244.00
		107	306	309	114.50	247.20
		108	310	314	115.60	251.20
		109	315	319	116.70	255.20
		110	320	323	117.70	258.40
		111	324	328	118.80	262.40
		112	329	333	119.90	266.40
		113	334	337	121.00	269.60
		114	338	342	122.00	273.60
		115	343	347	123.10	277.60
		116	348	351	124.20	280.80
		117	352	356	125.20	284.80
		118	357	361	126.30	288.80
		119	362	365	127.40	292.00
		120	366	370	128.40	296.00
		121	371	375	129.50	298.00
		122	376	379	130.60	299.60
		123	380	384	131.70	301.60
		124	385	389	132.70	303.60
		125	390	393	133.80	305.20
		126	394	398	134.90	307.20
		127	399	403	135.90	309.20
			404	407	137.00	310.80
			408	412	138.00	312.80
			413	417	139.00	314.80
			418	421	140.00	316.40
			422	426	141.00	318.40
			427	431	142.00	320.40
			432	436	143.00	322.40
			437	440	144.00	324.00
			441	445	145.00	326.00
			446	450	146.00	328.00
			451	454	147.00	329.60
			455	459	148.00	331.60
			460	464	149.00	333.60
			465	468	150.00	335.20
			469	473	151.00	337.20
			474	478	152.00	339.20
			479	482	153.00	340.80
			483	487	154.00	342.80
			488	492	155.00	344.80
			493	496	156.00	346.40
			497	501	157.00	348.40
			502	506	158.00	350.40
			507	510	159.00	352.00
			511	515	160.00	354.00
			516	520	161.00	356.00
			521	524	162.00	357.60
			525	529	163.00	359.60
			530	534	164.00	361.60
			535	538	165.00	363.20
			539	543	166.00	365.20
			544	548	167.00	367.20
			549	550	168.00	368.00

Average Monthly Wage

(b)(1) For the purposes of column III of the table appearing in subsection (a) of this section, an individual's "average monthly wage" shall be the quotient obtained by dividing—

(A) the total of his wages paid in and self-employment income credited to his "benefit computation years" (determined under paragraph (2)), by

(B) the number of months in such years.

(2)(A) The number of an individual's "benefit computation years" shall be equal to the number of elapsed years (determined under paragraph (3) of this subsection), reduced by five; except that the number of an individual's benefit computation years shall in no case be less than two.

(B) An individual's "benefit computation years" shall be those computation base years, equal in number to the number determined under subparagraph (A), for which the total of his wages and self-employment income is the largest.

[(C) For the purposes of subparagraph (B), "computation base years" include only calendar years occurring—

[(i) after December 31, 1950, and

[(ii) prior to the year in which the individual became entitled to old-age insurance benefits or died, whichever first occurred;

except that the year in which the individual became entitled to old-age insurance benefits or died, as the case may be, shall be included as a computation base year if the Secretary determines, on the basis of evidence available to him at the time of the computation of the primary insurance amount for such individual, that the inclusion of such year would result in a higher primary insurance amount. Any calendar year all of which is included in a period of disability shall not be included as a computation base year.]

(C) For purposes of subparagraph (B), "computation base years" include only calendar years in the period after 1950 and prior to the earlier of the following years—

(i) the year in which occurred (whether by reason of section 202(j)(1) or otherwise) the first month for which the individual was entitled to old-age insurance benefits, or

(ii) the year succeeding the year in which he died.

Any calendar year all of which is included in a period of disability shall not be included as a computation base year.

(3) For purposes of paragraph (2), the number of an individual's elapsed years is the number of calendar years after 1950 (or, if later, the year in which he attained age 21) and before—

[(A) in the case of a woman, the year in which she died or (if earlier) the first year after 1960 in which she both was fully insured and had attained age 62,

[(B) in the case of a man who has died, the year in which he died or (if earlier) the first year after 1960 in which he both was fully insured and had attained age 65, or

[(C) in the case of a man who has not died, the first year after 1960 in which he attained (or would attain) age 65 or (if later) the first year in which he was fully insured.]

(A) in the case of a woman, the year in which she died or, if it occurred earlier but after 1960, the year in which she attained age 62,

(B) in the case of a man who has died, the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 65, or

(C) in the case of a man who has not died, the year occurring after 1960 in which he attained (or would attain) age 65.

For purposes of the preceding sentence, any calendar year any part of which was included in a period of disability shall not be included in such number of calendar years.

[(4) The provisions of this subsection shall be applicable only in the case of an individual with respect to whom not less than six of the quarters elapsing after 1950 are quarters of coverage, and—

[(A) who becomes entitled to benefits after December 1960 under section 202(a) or section 223; or

[(B) who dies after December 1960 without being entitled to benefits under section 202(a) or section 223; or

[(C) who files an application for a recomputation under subsection (f)(2)(A) after December 1960 and is (or would, but for the provisions of subsection (f)(6), be) entitled to have his primary insurance amount recomputed under subsection (f)(2)(A); or

[(D) who dies after December 1960 and whose survivors are (or would, but for the provisions of subsection (f)(6), be) entitled to a recomputation of his primary insurance amount under subsection (f)(4).]

(4) The provisions of this subsection shall be applicable only in the case of an individual—

(A) who becomes entitled, after December 1965, to benefits under section 202(a) or section 223; or

(B) who dies after December 1965 without being entitled to benefits under section 202(a) or section 223; or

(C) whose primary insurance amount is required to be recomputed under subsection (f)(2), as amended by the Social Security Amendments of 1965;

except that it shall not apply to any such individual for purposes of monthly benefits for months before January 1966.

[(5) In the case of any individual—

[(A) to whom the provisions of this subsection are not made applicable by paragraph (4), but

[(B)(i) prior to 1961, met the requirements of this pargaraph (including subparagraph (E) thereof) as in effect prior to the enactment of the Social Security Amendments of 1960, or (ii) after 1960, meets the conditions of subparagraph (E) of this paragraph as in effect prior to such enactment.

then the provisions of this subsection as in effect prior to such enactment shall apply to such individual for the purposes of column III of the table appearing in subsection (a) of this section.]

(5) For the purposes of column III of the table appearing in subsection (a) of this section, the provisions of this subsection, as in effect prior to the enactment of the Social Security Amendments of 1965, shall apply—

(A) in the case of an individual to whom the provisions of this subsection are not made applicable by paragraph (4), but who, on or after the date of the enactment of the Social Security Amendments of 1965 and prior to 1966, met the requirements of

this paragraph or paragraph (4), as in effect prior to such enactment, and

(B) with respect to monthly benefits for months before January 1966, in the case of an individual to whom the provisions of this subsection are made applicable by paragraph (4).

[Primary Insurance Amount Under 1954 Act

[(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed as provided in, and subject to the limitations specified in, (A) this section as in effect prior to the enactment of the Social Security Amendments of 1958, and (B) the applicable provisions of the Social Security Amendments of 1954.

[(2) The provisions of this subsection shall be applicable only in the case of an individual—

[(A) who became entitled to benefits under section 202(a) or section 223 or died prior to January 1959, and

[(B) to whom the provisions of neither paragraph (4) nor paragraph (5) of subsection (b) are applicable.]

Primary Insurance Amount Under 1958 Act, as Modified

(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed as provided in, and subject to the limitations specified, (A) this section as in effect prior to the enactment of the Social Security Amendments of 1965, and

(B) the applicable provisions of the Social Security Amendments of 1960.

(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before the date of enactment of the Social Security Amendments of 1965 or who died before such date.

Primary Insurance Benefit Under 1939 Act

(d)(1) For the purposes of column I of the table appearing in subsection (a) of this section, an individual's primary insurance benefit shall be computed as provided in this title as in effect prior to the enactment of the Social Security Act Amendments of 1950, except that—

(A) In the computation of such benefit, such individual's average monthly wage shall (in lieu of being determined under section 209(f) of this title as in effect prior to the enactment of such amendments) be determined as provided in subsection (b) of this section (but without regard to paragraphs (4) and (5) thereof), except that for the purposes of paragraphs [(2)(C)(i) and (3)(A)(i)] *(2)(C) and (3)* of subsection *(b)*, [December 31, 1936,] *1936* shall be used instead of [December 31, 1950] *1950.*

(B For purposes of such computation, the date he became entitled to old-age insurance benefits shall be deemed to be the date he became entitled to primary insurance benefits.

(C) The 1 per centum addition provided for in section 209 (e) (2) of this Act as in effect prior to the enactment of the Social Security Act Amendments of 1950 shall be applicable only with respect to calendar years prior to 1951, except that any wages paid in any year prior to such year all of which was included in a period of disability shall not be counted.

(D) The provisions of subsection (e) shall be applicable to such computation.

(2) The provisions of this subsection shall be applicable only in the case of an individual—

(A) with respect to whom at least one of the quarters elapsing prior to 1951 is a quarter of coverage;

(B) who meets the requirements of any of the subparagraphs of paragraph (4) of subsection (b) of this section; and

(C) who attained age 22 after 1950 and with respect to whom less than six of the quarters elapsing after 1950 are quarters of coverage, or who attained such age before 1951.

(3) The provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of [1960] *1965* shall be applicable in the case of an individual who meets the requirements of subsection (b) (5) (as in effect after such enactment) [but without regard to whether such individual has six quarters of coverage after 1950].

Certain Wages and Self-Employment Income Not To Be Counted

(e) For the purposes of subsections (b) and (d)—

(1) in computing an individual's average monthly wage there shall not be counted the excess over $3,600 in the case of any calendar year after 1950 and before 1955, the excess over $4,200 in the case of any calendar year after 1954 and before 1959, [and the excess over $4,800 in the case of any calendar year after 1958] *the excess over $4,800 in the case of any calendar year after 1958 and before 1966 and the excess over $6,600 in the case of any calendar year after 1965* of (A) the wages paid to him in such year, plus (B) the self-employment income credited to such year (as determined under section 212); *and*

(2) if an individual's average monthly wage computed under subsection (b) or for the purposes of subsection (d) is not a multiple of $1, it shall be reduced to the next lower multiple of $1 [; and].

[(3) if an individual has self-employment income in a taxable year which begins prior to the calendar year in which he becomes entitled to old-age insurance benefits and ends after the last day of the month preceding the month in which he becomes so entitled, his self-employment income in such taxable year shall not be counted in determining his benefit computation years, except as provided in subsection (f) (3) (C).]

Recomputation of Benefits

(f) (1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in this

subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 217(b).

[(2)(A) Upon application filed after 1960 by an individual entitled to old-age insurance benefits, the Secretary shall recompute his primary insurance amount if—

[(i) he has not less than six quarters of coverage in the period after 1950 and prior to the quarter in which such application is filed,

[(ii) he has wages and self-employment income of more than $1,200 in a calendar year which occurs after 1953 (not taking into account any year prior to the calendar year in which the last previous recomputation, if any, of his primary insurance amount was effective) and after the year in which he became (without the application of section 202(j)(1) entitled to old-age insurance benefits or filed an application for recomputation (to which he is entitled) under section 102(c)(5)(B) or 102(f)(2)(B) of the Social Security Amendments of 1954, whichever of such events is the latest, and

[(iii) he filed such application after such calendar year referred to in clause (ii) in which he had such wages and self-employment income.

Such recomputation shall be effective for and after the twelfth month before the month in which he filed such application for recomputation but in no event earlier than the month following such calendar year referred to in clause (ii). For the purposes of this subparagraph an individual's self-employment income shall be allocated to calender quarters in accordance with section 212.

[(B) A recomputation pursuant to subparagraph (A) shall be made—

[(i) only as provided in subsection (a)(1), if the provisions of subsection (b), as amended by the Social Security Amendments of 1960, were applicable to the last previous computation of the individual's primary insurance amount, or

[(ii) as provided in subsection (a) (1) and (3), in all other cases.

Such recomputation shall be made as though the individual became entitled to old-age insurance benefits in the month in which he filed the application for such recomputation, except that if clause (i) of this subparagraph is applicable to such recomputation, the computation base years referred to in subsection (b)(2) shall include only calendar years occurring prior to the year in which he filed his application for such recomputation.]

(2) With respect to each year—

(A) which begins after December 31, 1964, and

(B) for any part of which an individual is entitled to old-age insurance benefits,

the Secretary shall, at such time or times and within such period as he may by regulations prescribe, recompute the primary insurance amount of such individual. Such recompuation shall be made—

(C) as provided in subsection (a) (1) and (3) if such year is either the year in which he became entitled to such old-age insurance benefits or the year preceding such year, or

(D) as provided in subsection (a)(1) in any other case;

and in all cases such recomputation shall be made as though the year with respect to which such recomputation is made is the last year of

the period specified in paragraph (2)(C) of subsection (b). A recomputation under this paragraph with respect to any year shall be effective—

(E) in the case of an individual who did not die in such year, for monthly benefits beginning with benefits for January of the following year; or

(F) in the case of an individual who died in such year (including any individual whose increase in his primary insurance amount is attributable to compensation which, upon his death, is treated as remuneration for employment under section 205(o)), for monthly benefits beginning with benefits for the month in which he died.

[(3)(A) Upon application by an individual—

[(i) who became entitled to old-age insurance benefits under section 202(a) after December 1960, or

[(ii) whose primary insurance amount was recomputed as provided in paragraph (2)(B)(ii) of this subsection on the basis of an application filed after December 1960,

the Secretary shall recompute his primary insurance amount if such application is filed after the calendar year in which he became entitled to old-age insurance benefits or in which he filed application for the recomputation of his primary insurance amount under clause (ii) of this sentence, whichever is the later. Such recomputation under this subparagraph shall be made as provided in subsection (a) (1) and (3) of this section, except that such individual's computation base years referred to in subsection (b)(2) shall include the calendar year referred to in the preceding sentence. Such recomputation under this subparagraph shall be effective for and after the first month for which his last previous computation of his primary insurance amount was effective, but in no event for any month prior to the twenty-fourth month before the month in which the application for such recomputation is filed.

[(B) In the case of an individual who dies after December 1960 and—

[(i) who, at the time of death was not entitled to old-age insurance benefits under section 202(a), or

[(ii) who became entitled to such old-age insurance benefits after December 1960, or

[(iii) whose primary insurance amount was recomputed under paragraph (2) of this subsection on the basis of an application filed after December 1960, or

[(iv) whose primary insurance amount was recomputed under paragraph (4) of this subsection,

the Secretary shall recompute his primary insurance amount upon the filing of an application by a person entitled to monthly benefits or a lump-sum death payment on the basis of such individual's wages and self-employment income. Such recomputation shall be made as provided in subsection (a) (1) and (3) of this section, except that such individual's computation base years referred to in subsection (b)(2) shall include the calendar year in which he died in the case of an individual who was not entitled to old-age insurance benefits at the time of death or whose primary insurance amount was recomputed under paragraph (4) of this subsection, or in all other cases, the calendar year in which he filed his application for the last previous computation

of his primary insurance amount. In the case of monthly benefits, such recomputation shall be effective for and after the month in which the person entitled to such monthly benefits became so entitled, but in no event for any month prior to the twenty-fourth month before the month in which the application for such recomputation is filed.

[(C) In the case of an individual who becomes entitled to old-age insurance benefits in a calendar year after 1960, if such individual has self-employment income in a taxable year which begins prior to such calendar year and ends after the last day of the month preceding the month in which he became so entitled, the Secretary shall recompute such individual's primary insurance amount after the close of such taxable year and shall take into account in determining the individual's benefit computation years only such self-employment income in such taxable year as is credited, pursuant to section 212, to the year preceding the year in which he became so entitled. Such recomputation shall be effective for and after the first month in which he became entitled to old-age insurance benefits.

[(4) Upon the death after 1960 of an individual entitled to old-age insurance benefits, if any person is entitled to monthly benefits, or to a lump-sum death payment, on the basis of the wages and self-employment income of such individual, the Secretary shall recompute the decedent's primary insurance amount, but only if—

[(A) the decedent would have been entitled to a recomputation under paragraph (2)(A) if he had filed application therefor in the month in which he died; or

[(B) the decedent during his lifetime was paid compensation which was treated under section 205(o) as remuneration for employment.

If the recomputation is permitted by subparagraph (A) the recomputation shall be made (if at all) as though he had filed application for a recomputation under paragraph (2)(A) in the month in which he died. If the recomputation is permitted by subparagraph (B), the recomputation shall take into account only the wages and self-employment income which were considered in the last previous computation of his primary insurance amount and the compensation (described in section 205(o) paid to him in the years in which such wages were paid or to which such self-employment income was credited. If both of the preceding sentences are applicable to an individual, only the recomputation which results in the larger primary insurance amount shall be made.]

[(5)](*3*)(5) In the case of any individual who became entitled to old-age insurance benefits in 1952 or in a taxable year which began in 1952 (and without the application of section 202(j)(1)), or who died in 1952 or in a taxable year which began in 1952 but did not become entitled to such benefits prior to 1952, and who had self-employment income for a taxable year which ended within or with 1952 or which began in 1952, then upon application filed by such individual after the close of such taxable year and prior to January 1961 or (if he died without filing such application and such death occurred prior to January 1961) by a person entitled to monthly benefits on the basis of such individual's wages and self-employment income, the Secretary shall recompute such individual's primary insurance amount. Such recomputation shall be made in the manner provided in the preceding subsections of this section (other than subsection (b)(4)(A)) for com-

putation of such amount, except that (A) the self-employment income closing date shall be the day following the quarter with or within which such taxable year ended, and (B) the self-employment income for any subsequent taxable year shall not be taken into account. Such recomputation shall be effective (A) in the case of an application filed by such individual, for and after the first month in which he became entitled to old-age insurance benefits, and (B) in the case of an application filed by any other person, for and after the month in which such person who filed such application for recomputation became entitled to such monthly benefits. No recomputation under this paragraph pursuant to an application filed after such individual's death shall affect the amount of the lump-sum death payment under subsection (i) of section 202, and no such recomputation shall render erroneous any such payment certified by the Secretary prior to the effective date of the recomputation.

[(6)](4)(6) Any recomputation under this subsection shall be effective only if such recomputation results in a higher primary insurance amount.

[(7)(A) In the case of a man who attains age 65 and who became entitled to old-age insurance benefits before the month in which he attains such age, his primary insurance amount shall be recomputed as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he attained age 65, except that his computation base years referred to in subsection (b)(2) shall include the year in which he attained age 65. Such recomputation shall be effective for and after the month in which he attained age 65.

[(B) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained age 65, the Secretary shall, if any person is entitled to monthly insurance benefits or a lump-sum death payment on the basis of the wages and self-employment income of the decedent, recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he died; except that (i) his computation base years referred to in subsection (b)(2) shall include the year in which he died, and (ii) his elapsed years referred to in subsection (b)(3) shall not include the year in which he died or any year thereafter. In the case of monthly insurance benefits, such recomputation of a man's primary insurance amount shall be effective for and after the month in which he died.]

Rounding of Benefits

(g) The amount of any primary insurance amount and the amount of any monthly benefit computed under section 202 or 223 which (after reduction under section 203(a) and deductions under section 203(b)) is not a multiple of $0.10 shall be raised to the next higher multiple of $0.10.

(h)(1) Notwithstanding the provisions of the Civil Service Retirement Act, remuneration paid for service to which the provisions of section 210(l)(1) of this Act are applicable and which is performed by an individual as a commissioned officer of the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under

this title, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Civil Service Commission certifies to the Secretary that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or if he has died, to his widow and children, under the Civil Service Retirement Act on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

Other Definitions

Sec. 216. For the purposes of this title—

Wife

(b) The term "wife" means the wife of an individual, but only if she (1) is the mother of his son or daughter, (2) was married to him for a period of not less than one year immediately preceding the day on which her application is filed, or (3) in the month prior to the month of her marriage to him (A) was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection [(e) or] (*b*), (*e*), *or* (h) of section 202, [or] (B) had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (*subject, however to section 202 (s)*), *or (C) was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.*

Widow

(c) The term "widow" (except when used in section 202(i)) means the surviving wife of an individual, but only if (1) she is the mother of his son, or daughter, (2) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (3) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (4) she was married to him at the time both of them legally adopted a child under the age of eighteen, (5) she was married to him for a period of not less than one year immediately prior to the day on which he died, or (6) in the month prior to the month of her marriage to him (A) she was entitled to, or an application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection [(*e*) *or*] (*b*), (*e*), *or* (h) of section 202, [*or*] (B) she had attained age eighteen and was entitled to, or on

application therefor would have been entitled to, benefits under subsection (d) of such section (*subject, however, to section 202(s)*), *or (C) she was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.*

Former Wife Divorced

[(d) The term "former wife divorced" means a woman divorced from an individual, but only if (1) she is the mother of his son or daughter, (2) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (3) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, or (4) she was married to him at the time both of them legally adopted a child under the age of eighteen.]

Divorced Wives; Divorce

(d) (1) The term "divorced wife" means a woman divorced from an individual, but only if she had been married to such individual for a period of 20 years immediately before the date the divorce became effective.

(2) The term "surviving divorced wife" means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 20 years immediately before the date the divorce became effective.

(3) The term "surviving divorced mother" means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18, or (D) she was married to him at the time both of them legally adopted a child under the age of 18.

(4) The terms "divorce" and "divorced" refer to a divorce a vinculo matrimonii.

Child

(e) The term "child" means (1) the child or legally adopted child of an individual, and (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) the day on which such individual died. For purposes of clause (1), a person shall be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if such person was at the time of such individual's death living in such individual's household and was legally adopted by such individual's surviving spouse after such individual's death but before the end of two years after the day on which such individual died or the date of enactment of this Act; except that this sentence shall not apply if at the time of such individual's death such person was receiving regular contributions toward his support from someone other than such individual or his spouse, or from any public or private welfare organization which furnishes services or assistance for children. For purposes of clause

(2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage.

Husband

(f) The term "husband" means the husband of an individual, but only if (1) he is the father of her son or daughter, (2) he was married to her for a period of not less than one year immediately preceding the day on which his application is filed, or (3) in the month prior to the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to benefits under subsection (f) or (h) of section 202, [or] (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (*subject, however, to section 202 (s)*), *or (C) he was entitled to, or upon application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.*

Widower

(g) The term "widower" (except when used in section 202(i) means the surviving husband of an individual, but only if (1) he is the father of her son or daughter, (2) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (3) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (4) he was married to her at the time both of them legally adopted a child under the age of eighteen, (5) he was married to her for a period of not less than one year immediately prior to the day on which she died, or (6) in the month before the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (f) or (h) of section 202 [or] (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (*subject however, to section 202(s)*), *or (C) he was entitled to, or on application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.*

Determination of Family Status

(h)(1)(A) An applicant is the wife, husband, widow, or widower of a fully or currently insured individual for purposes of this title if the courts of the State in which such insured individual is domiciled at the times such applicant files an application, or, if such insured indi-

vidual is dead, the courts of the State in which he was domiciled at the time of death, or, if such insured individual is or was not so domiciled in any State, the courts of the District of Columbia, would find that such applicant and such insured individual were validly married at the time such applicant files such application or, if such insured individual is dead, at the time he died. If such courts would not find that such applicant and such insured individual were validly married at such time, such applicant shall, nevertheless be deemed to be the wife, husband, widow, or widower, as the case may be, of such insured individual if such applicant would, under the laws applied by such courts in determining the devolution of intestate personal property, have the same status with respect to the taking of such property as a wife, husband, widow, or widower of such insured individual.

(B) In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual, but it is established to the satisfaction of the Secretary that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage, and such applicant and the insured individual were living in the same household at the time of the death of such insured individual or (if such insured individual is living) at the time such applicant files the application, then, for purposes of subparagraph (A) and subsections (b), (c), (f), and (g), such purported marriage shall be deemed to be a valid marriage. The provisions of the preceding sentence shall not apply (i) if another person is or has been entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual and such other person is (or is deemed to be) a wife, widow, husband, or widower of such insured individual under subparagraph (A) at the time such applicant files the application, or (ii) if the Secretary determines, on the basis of information brought to his attention, that such applicant entered into such purported marriage with such insured individual with knowledge that it would not be a valid marriage. The entitlement to a monthly benefit under subsection (b), (c), (e), (f), or (g) of section 202, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife, widow, husband, or widower of such insured individual but for this subparagraph, shall end with the month before the month (i) in which the Secretary certifies, pursuant to section 205 (i), that another person is entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual, if such other person is (or is deemed to be) the wife, widow, husband, or widower of such insured individual under subparagraph (A), or (ii) if the applicant is entitled to a monthly benefit under subsection (b) or (c) of section 202, in which such applicant entered into a marriage, valid without regard to this subparagraph, with a person other than such insured individual. For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an inpediment (i)

resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or (ii) resulting from a defect in the procedure followed in connection with such purported marriage.

(2) (A) In determining whether an applicant is the child or parent of a fully or currently insured individual for purposes of this title, the Secretary shall apply such law as would be applied in determining the devolution of intestate personal property by the courts of the State in which such insured individual is domiciled at the time such applicant files application, or, if such insured individual is dead, by the courts of the State in which he was domiciled at the time of his death, or, if such insured individual is or was not so domiciled in any State, by the courts of the District of Columbia. Applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.

(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to be) the child of such insured individual under subparagraph (A), such applicant shall nevertheless be deemed to be the child of such insured individual if such insured individual and the mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1) (B), would have been a valid marriage.

(3) An applicant who is the son or daughter of a fully or currently insured individual, but who is not (and is not deemed to be) the child of such insured individual under paragraph (2), shall nevertheless be deemed to be the child of such insured individual if:

(A) in the case of an insured individual entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits)—

(i) such insured individual—

(I) has acknowledge in writing that the applicant is his son or daughter,

(II) has been decreed by a court to be the father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his son or daughter,

and such acknowledgement, court decree, or court order was made not less than one year before such insured individual became entitled to old-age insurance benefits or attained age 65, whichever is earlier; or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to be the father of the applicant and was living with or contributing to the support of the applicant at the time such insured individual became entitled to benefits or attained age 65, whichever first occurred;

(B) in the case of an insured individual entitled to disability insurance benefits, or who was entitled to such benefits in the month preceding the first month for which he was entitled to old-age insurance benefits—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his son or daughter,

(II) has been decreed by a court to be the father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his son or daughter,

and such acknowledgment, court decree, or court order was made before such insured individual's most recent period of disability began; or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to be the father of the applicant and was living with or contributing to the support of that applicant at the time such disability began;

(C) in the case of a deceased individual—

(i) such insured individual—

(I) had acknowledged in writing that the applicant is his son or daughter,

(II) had been decreed by a court to be the father of the applicant, or

(III) had been ordered by a court to contribute to the support of the applicant because the applicant was his son or daughter,

and such acknowledgement, court decree, or court order was made before the death of such insured individual, or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to have been the father of the applicant, and such insured individual was living with or contributing to the support of the applicant at the time such insured individual died.

Disability; Period of Disability

(i)(1) Except for purposes of section 202(d), 223, [and 225, the term "disability" means (A) inability 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] *or has lasted or can be expected to last for a continuous period of not less than 12 calendar months*, or (B) blindness; and the term "blindness" means central visual acuity of 5/200 or less in the better eye with the use of a correcting lens. An eye in which the visual field is reduced to five degrees or less concentric contraction shall be considered for the purpose of this paragraph as having a central visual acuity of 5/200 or less. An individual shall not be considered to be under a disability unless he furnishes such proof of the existence thereof as may be required. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

[(2) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than six full calendar months' duration or such individual was entitled to benefits under sec-

tion 223 for one or more months in such period. No such period shall begin as to any individual unless such individual, while under such disability, files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains the age of sixty-five. A period of disability shall [(subject to section 223(a)(3))] begin—

[(A) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

[(B) if such individual does not satisfy the requirement of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

A period of disability shall end with the close of the last day of the month preceding whichever of the following months is the earlier: the month in which the individual attains age sixty-five or the third month following the month in which the disability ceases. No application for a disability determination which is filed more than three months before the first day on which a period of disability can begin (as determined under this paragraph), or, in any case in which clause (ii) of section 223(a)(1) is applicable, more than six months before the first month for which such applicant becomes entitled to benefits under section 223, shall be accepted as an application for purposes of this paragraph, and no such application which is filed prior to January 1, 1955, shall be accepted. Any application for a disability determination which is filed within such three months' period or six months' period shall be deemed to have been filed on such first day or in such first month, as the case may be.]

(2)(A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than 6 full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains the age of 65.

(C) A period of disability shall begin—

(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains age 65, or (ii) the second month following the month in which the disability ceases.

(E) No application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application

only if the applicant satisfies the requirements for a period of disability before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed on such first day.

(3) The requirements referred to in [clauses (A) and (B) of paragraph (2)] *clauses (i) and (ii) of paragraph (2)(C)* are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 (if a woman) or age 65 (if a man) and filed application for benefits under section 202(a) on the first day of such quarter; and

(B) he had not less than twenty quarters of coverage during the forty-quarter period which ends with such quarter, not counting as part of such forty-quarter period any part of which was included in a prior period of disability unless such quarter was a quarter of coverage;

except that the provisions of subparagraph (A) of this paragraph shall not apply in the case of any individual with respect to whom a period of disability would, but for such subparagraph, begin prior to 1951.

Periods of Limitation Ending on Nonwork Days

(j) Where this title, any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of this title, or any regulation issued by the Secretary pursuant thereto provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Secretary pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this title may (pursuant to section 202(j)(1) or 223(b)) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this title may (pursuant to section 202(j)(2) or 223(b)) be accepted as such.

Benefits in Case of Veterans

Sec. 217. (a)(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any World War II veteran, and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which

he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality. The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veterans, the Secretary of Health, Education, and Welfare shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran during World War II, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary of Health, Education, and Welfare shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service during World War II shall, at the request of the Secretary of Health, Education, and Welfare, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(b)(1) Any World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 215(c). Notwithstanding section 215(d), the primary insurance benefit (for purposes of section 215(c)) of such veteran shall be determined as provided in this title as in

effect prior to the enactment of this section, except that the 1 per centum addition provided for in section 209(e)(2) of this Act as in effect prior to the enactment of this section shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death-payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Veterans' Administration to be payable by it on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to paragraph (1)(B) of this subsection unless he has been notified by the Veterans' Administration that pension or compensation is determined to be payable by the Veterans' Administration by reason of the death of such veteran. The Secretary of Health, Education, and Welfare shall thereupon report such decision to the Veterans' Administration. If the Veterans' Administration in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, it shall notify the Secretary of Health, Education, and Welfare and the Secretary shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payment theretofore certified by the Secretary of Health, Education, and Welfare on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Veterans' Administration, shall (notwithstanding the provisions of section 3101 of title 38, United States Code) be deemed to have been paid to him by such Administration on account of such accrued pension or compensation. No such payment certified by the Secretary of Health, Education, and Welfare, and no payment certified by him for any month prior to the first month for which any pension or compensation is paid by the Veterans' Administration shall be deemed by reason of this subsection to have been an erroneous payment.

(c) In the case of any World War II veterans to whom subsection (a) is applicable, proof of support required under section 202(h) may be filed by a parent at any time prior to July 1951 or prior to the expiration of two years after the date of the death of such veteran, whichever is the later.

(d) For the purposes of this section—

(1) The term "World War II" means the period beginning with September 16, 1940, and ending at the close of July 24, 1947.

(2) The term "World War II veteran" means any individual who served in the active military or naval service of the United States at any time during World War II and who, if discharged

or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(e) (1) For purposes of determining entitlement to and the amount of any monthly benefit or lump-sum death payment payable under this title on the basis of wages and self-employment income of any veteran (as defined in paragraph (4)), and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States on or after July 25, 1947, and prior to January 1, 1957. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3). In the case of monthly benefits under this title for months after December 1956 (and any lump-sum death payment under this title with respect to a death occurring after December 1956) based on the wages and self-employment income of a veteran who performed service (as a member of a uniformed service) to which the provisions of section 210(l)(1) are applicable, wages which would, but for the provisions of clause (B), be deemed under this subsection to have been paid to such veteran with respect to his active military or naval service performed after December 1950 shall be deemed to have been paid to him with respect to such service notwithstanding the provisions of such clause, but only if the benefits referred to in such clause which are based (in whole or in part) on such service are payable solely by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey or Public Health Service.

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to clause (B) of paragraph (1) of this subsection un-

less he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary of Health, Education, and Welfare shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph 1 of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service on or after July 25, 1947, and prior to January 1, 1957, shall, at the request of the Secretary of Health, Education, and Welfare, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(4) For the purposes of this subsection, the term "veteran" means any individual who served in the active military or naval service of the United States at any time on or after July 25, 1947, and prior to January 1, 1957, and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(f)(1) In any case where a World War II veteran (as defined in subsection (d)(2)) or a veteran (as defined in subsection (e)(4)) has died or shall hereafter die, and his widow or child is entitled under the Civil Service Retirement Act of May 29, 1930, as amended, to an annuity in the computation of which his active military or naval service was included, clause (B) of subsection (a)(1) or clause (B) of subsection (e)(1) shall not operate (solely by reason of such annuity) to make such subsection inapplicable in the case of any monthly benefit under section 202 which is based on his wages and self-employment income; except that no such widow or child shall be entitled under section 202 to any monthly benefit in the computation of which such service is included by reason of this subsection (A) unless such widow or child after December 1956 waives his or her right to receive such annuity, or (B) for any month prior to the first month with respect to which the Civil Service Commission certifies to the Secretary of Health, Education, and Welfare that (by reason of such waiver) no further annuity will be paid to such widow or child under such Act of May 29, 1930, as amended, on the basis of such veteran's military or civilian service. Any such wiaver shall be irrevocable.

(2) Whenever a widow waives her right to receive such annuity such waiver shall constitute a waiver on her own behalf; a waiver

by a legal guardian or guardians, or, in the absence of a legal guardian, the person (or persons) who has the child in his care, of the child's right to receive such annuity shall constitute a waiver on behalf of such child. Such a waiver with respect to an annuity based on a veteran's service shall be valid only if the widow and all children, or, there is no widow, all the children, waive their rights to receive annuities under the Civil Service Retirement Act of May 29, 1930, as amended, based on such veteran's military or civilian service.

[(g)(1) There are hereby authorized to be appropriated to the Trust Fund annually, as benefits under this title are paid after June 1956, such sums as the Secretary of Health, Education, and Welfare determines to be necessary to meet the addition costs, resulting from subsections (a), (b), and (e), of such benefits (including lump-sum death payments).

[(2) The Secretary shall, before October 1, 1958, determine the amount which would place the Federal Old-Age and Survivors Insurance Trust Fund in the same position in which it would have been at the close of June 30, 1956, if section 210 of this Act, as in effect prior to the Social Security Act Amendments of 1950, and section 217 of this Act (including amendments thereof), had not been enacted. There are hereby authorized to be appropriated to such Trust Fund annually, during the first ten fiscal years beginning after such determination is made, sums aggregating the amount so determined, plus interest accruing on such amount (as reduced by appropriations made pursuant to this paragraph) for each fiscal year beginning after June 30, 1956, at a rate for such fiscal year equal to the average rate of interest (as determined by the Managing Trustee) earned on the invested assets of such Trust Fund during the preceding fiscal year.]

(g)(1) In September 1965, and in every fifth September thereafter up to and including September 2010, the Secretary shall determine the amount which, if paid in equal installments at the beginning of each fiscal year in the period beginning—

(A) with July 1, 1965, in the case of the first such determination, and

(B) with the July 1 following the determination in the case of all other such determinations,

and ending with the close of June 30, 2015, would accumulate, with interest compounded annually, to an amount equal to the amount needed to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of June 30, 2015, as he estimates they would otherwise be in at the close of that date if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted. The rate of interest to be used in determining such amount shall be the rate determined under section 201(d) for public-debt obligations which were or could have been issued for purchase by the Trust Funds in the June preceding the September in which such determination is made.

(2) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund—

(A) for the fiscal year ending June 30, 1966, an amount equal to the amount determined under paragraph (1) in September 1965, and

(B) for each fiscal year in the period beginning with July 1, 1966, and ending with the close of June 30, 2015, an amount equal to the annual installment for such fiscal year under the most recent

determination under paragraph (1) which precedes such fiscal year.

(3) For the fiscal year ending June 30, 2016, there is authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position in which they would have been at the close of June 30, 2015, if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted.

(4) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund annually, as benefits under this title and part A of title XVIII are paid after June 30, 2015, such sums as the Secretary determines to be necessary to meet the additional costs, resulting from subsections (a), (b), and (e), of such benefits (including lump-sum death payments).

Gratuitous Wage Credits for American Citizens Who Served in the Armed Forces of Allied Countries

(h)(1) For the purposes of this section, any individual who the Secretary finds—

(A) served during World War II (as defined in subsection (d)(1)) in the active military or naval service of a country which was on September 16, 1940, at war with a country with which the United States was at war during World War II;

(B) entered into such active service on or before December 8, 1941;

(C) was a citizen of the United States throughout such period of service or lost his United States citizenship solely because of his entrance into such service;

(D) had resided in the United States for a period or periods aggregating four years during the five-year period ending on the day of, and was domiciled in the United States on the day of, such entrance into such active service; and

(E)(i) was discharged or released from such service under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty, or

(ii) died while in such service,

shall be considered a World War II veteran (as defined in subsection (d)(2)) and such service shall be considered to have been performed in the active military or naval service of the United States.

(2) In the case of any individual to whom paragraph (1) applies, proof of support required under section 202 (f) or (h) may be filed at any time prior to the expiration of two years after the date of such individual's death or the date of the enactment of this subsection, whichever is the later.

Voluntary Agreements for Coverage of State and Local Employees

Purpose of Agreement

Sec. 218. (a)(1) The Secretary of Health, Education, and Welfare shall, at the request of any State, enter into an agreement with such

State for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such State or any political subdivision thereof. Each such agreement shall contain such provisions, not inconsistent with the provisions of this section, as the State may request.

(2) Notwithstanding section 210(a), for the purposes of this title the term "employment" includes any service included under an agreement entered into under this section.

Definitions

(b) For the purposes of this section—

(1) The term "State" does not include the District of Columbia, Guam or American Samoa.

(2) The term "political subdivision" includes an instrumentality of (A) a State, (B) one or more political subdivisions of a State, or (C) a State and one or more of its political subdivisions.

(3) The term "employee" includes an officer of a State or political subdivision.

(4) The term "retirement system" means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

(5) The term "coverage group" means (A) employees of the State other than those engaged in performing service in connection with a proprietary function; (B) employees of a political subdivision of a State other than those engaged in performing service in connection with a proprietary function; (C) employees of a State engaged in performing service in connection with a single proprietary function; or (D) employees of a political subdivision of a State engaged in performing service in connection with a single proprietary function. If under the preceding sentence an employee would be included in more than one coverage group by reason of the fact that he performs service in connection with two or more proprietary functions or in connection with both a proprietary function and a nonproprietary function, he shall be included in only one such coverage group. The determination of the coverage group in which such employee shall be included shall be made in such manner as may be specified in the agreement. Civilian employees of National Guard units of a State who are employed pursuant to section 90 of the National Defense Act of June 3, 1916 (32 U.S.C., sec. 42), and paid from funds allotted to such units by the Department of Defense, shall for purposes of this section be deemed to be employees of the State and (notwithstanding the preceding provisions of this paragraph), shall be deemed to be a separate coverage group. For purposes of this section, individuals employed pursuant to an agreement, entered into pursuant to section 205 of the Agricultural Marketing Act of 1946 (7 U.S.C. 1624) or section 14 of the Perishable Agricultural Commodities Act, 1930 (7 U.S.C. 499n), between a State and the United States Department of Agriculture to perform services as inspectors of agricultural products may be deemed, at the option of the State, to be employees of the State and (notwithstanding the preceding provisions of this paragraph) shall be deemed to be a separate coverage group.

Services Covered

(c)(1) An agreement under this section shall be applicable to any one or more coverage groups designated by the State.

(2) In the case of each coverage group to which the agreement applies, the agreement must include all services (other than services excluded by or pursuant to subsection (d) or paragraph (3), (5), or (6) of this subsection) performed by individuals as members of such group.

(3) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any one or more of the following:

(A) Any service of an emergency nature;

(B) All services in any class or classes of (i) elective positions, (ii) part-time positions, or (iii) positions the compensation for which is on a fee basis;

(C) All services performed by individuals as members of a coverage group in positions covered by a retirement system on the date such agreement is made applicable to such coverage group, but only in the case of individuals who, on such date (or, if later, the date on which they first occupy such positions), are not eligible to become members of such system and whose services in such positions have not already been included under such agreement pursuant to subsection (d)(3).

(4) The Secretary of Health, Education, and Welfare shall, at the request of any State, modify the agreement with such State so as to (A) include any coverage group to which the agreement did not previously apply, or (B) include, in the case of any coverage group to which the agreement applies, services previously excluded from the agreement; but the agreement as so modified may not be inconsistent with the provisions of this section applicable in the case of an original agreement with a State. A modification of an agreement pursuant to clause (B) of the preceding sentence may apply to individuals to whom paragraph (3)(C) is applicable (whether or not the previous exclusion of the service of such individuals was pursuant to such paragraph), but only if such individuals are, on the effective date specified in such modification, ineligible to be members of any retirement system or if the modification with respect to such individuals is pursuant to subsection (d)(3).

(5) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any agricultural labor, or service performed by a student, designated by the State. This paragraph shall apply only with respect to service which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section and service the remuneration for which is excluded from wages by paragraph (2) of section 209(h).

(6) Such agreement shall exclude—

(A) service performed by an individual who is employed to relieve him from unemployment,

(B) service performed in a hospital, home, or other institution by a patient or inmate thereof,

(C) covered transportation service (as determined under section 210(k)), and

(D) service (other than agricultural labor or service performed by a student), which is excluded from employment by any pro-

vision of section 210(a) other than paragraph (7) of such section.

(7) No agreement may be made applicable (either in the original agreement or by any modification thereof) to service performed by any individual to whom paragraph (3)(C) is applicable unless such agreement provides (in the case of each coverage group involved) either that the service of any individual to whom such paragraph is applicable and who is a member of such coverage group shall continue to be covered by such agreement in case he thereafter becomes eligible to be a member of a retirement system, or that such service shall cease to be so covered when he becomes eligible to be a member of such a system (but only if the agreement is not already applicable to such system pursuant to subsection (a)(3)), whichever may be desired by the State.

Positions Covered by Retirement Systems

(d)(1) No agreement with any State may be made applicable (either in the original agreement or by any modification thereof) to any service performed by employees as members of any coverage group in positions covered by a retirement system either (A) on the date such agreement is made applicable to such coverage group, or (B) on the date of enactment of the succeeding paragraph of this subsection (except in the case of positions which are, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of enactment of such succeeding paragraph, no longer covered by a retirement system on the date referred to in clause (A), and except in the case of positions excluded by paragraph (5)(A)). The preceding sentence shall not be applicable to any service performed by an employee as a member of any coverage group in a position (other than a position excluded by paragraph (5)(A)) covered by a retirement system on the date an agreement is made applicable to such coverage group if, on such date (or, if later, the date on which such individual first occupies such position), such individual is ineligible to be a member of such system.

(2) It is hereby declared to be the policy of the Congress in enacting the succeeding paragraphs of this subsection that the protection afforded employees in positions covered by a retirement system on the date an agreement under this section is made applicable to service performed in such positions, or receiving periodic benefits under such retirement system at such time, will not be impaired as a result of making the agreement so applicable or as a result of legislative enactment in anticipation thereof.

(3) Notwithstanding paragraph (1), an agreement with a State may be made applicable (either in the original agreement or by any modification thereof) to service performed by employees in positions covered by a retirement system (including positions specified in paragraph (4) but not including positions excluded by or pursuant to paragraph (5)), if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary of Health, Education, and Welfare that the following conditions have been met:

(A) A referendum by secret written ballot was held on the question of whether service in positions covered by such retirement system should be excluded from or included under an agreement under this section;

(B) An opportunity to vote in such referendum was given (and was limited) to eligible employees;

(C) Not less than ninety days' notice of such referendum was given to all such employees;

(D) Such referendum was conducted under the supervision of the governor or an agency or individual designated by him; and

(E) A majority of the eligible employees voted in favor of including service in such positions under an agreement under this section.

An employee shall be deemed an "eligible employee" for purposes of any referendum with respect to any retirement system, if, at the time such referendum was held, he was in a position covered by such retirement system and was a member of such system, and if he was in such a position at the time notice of such referendum was given as required by clause (C) of the preceding sentence; except that he shall not be deemed an "eligible employee" if, at the time the referendum was held, he was in a position to which the State agreement already applied or if he was in a position excluded by or pursuant to paragraph (5). No referendum with respect to a retirement system shall be valid for purposes of this paragraph unless held within the two-year period which ends on the date of execution of the agreement or modification which extends the insurance system established by this title to such retirement system, nor shall any referendum with respect to a retirement system be valid for purposes of this paragraph if held less than one year after the last previous referendum held with respect to such retirement system.

(4) For the purposes of subsection (c) of this section, the following employees shall be deemed to be a separate coverage group—

(A) all employees in positions which were covered by the same retirement system on the date the agreement was made applicable to such system (other than employees to whose services the agreement already applied on such date);

(B) all employees in positions which became covered by such system at any time after such date; and

(C) all employees in positions which were covered by such system at any time before such date and to whose services the insurance system established by this title has not been extended before such date because the positions were covered by such retirement system (including employees to whose services the agreement was not applicable on such date because such services were excluded pursuant to subsection (c)(3)(C)).

(5)(A) Nothing in paragraph (3) of this subsection shall authorize the extension of the insurance system established by this title to service in any policeman's or fireman's position.

(B) At the request of the State, any class or classes of positions covered by a retirement system which may be excluded from the agreement pursuant to paragraph (3) or (5) of subsection (c), and to which the agreement does not already apply, may be excluded from the agreement at the time it is made applicable to such retirement system; except that, notwithstanding the provisions of paragraph (3)(C) of such subsection, such exclusion may not include any services to which such paragraph (3)(C) is applicable. In the case of any such exclusion, each such class so excluded shall, for purposes of this subsection, constitute a separate retirement system in case of any modification of the agreement thereafter agreed to.

(6) (A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisins of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of a State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (f) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

(B) If a retirement system covers positions of employees of one or more institutions of higher learning, then, for purposes of such preceding paragraphs, there shall, if the State so desires, be deemed to be a separate retirement system for the employees of each such institution of higher learning. For the purposes of this subparagraph, the term "institutions of higher learning" includes junior colleges and teachers colleges. If a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of the preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

(C) For the purposes of this subsection, any retirement system established by the State of *Alaska*, California, Connecticut, Florida, Georgia, Massachusetts Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, Wisconsin, or Hawaii, or any political subdivision of any such State, which, on, before, or after the date of enactment of this subparagraph, is divided into two divisions or parts, one of which is composed of positions of members of such system who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who do not desire such coverage, shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring such coverage the positions of individuals who become members of such system after such coverage is extended, be deemed to be a separate retirement system with respect to each such division or part. If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under and agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the posi-

tions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agreement under this section and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph.

(D) The position of any individual which is covered by any retirement system to which subparagraph (C) is applicable shall, if such individual is ineligible to become a member of such system on August 1, 1956, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title.

(E) An individual who is in a position covered by a retirement system to which subparagraph (C) is applicable and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection (other than paragraph (8)), be regarded as a member of such system; except that, in the case of any retirement system a division or part of which is covered under the agreement (either in the original agreement or by a modification thereof), which coverage is agreed to prior to 1960, the preceding provisions of this subparagraph shall apply only if the State so requests and any such individual referred to in such preceding provisions shall, if the State so requests, be treated, after division of the retirement system pursuant to such subparagraph (C), the same as individuals in positions referred to in subparagraph (F).

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Secretary prior to [1963] *1967* or, if later, the expiration of two years after the date on which such agreement, or the modification thereof making the agreement applicable to such separate retirement system, as the case may be, is agreed to, but only if, prior to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection (f)(1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

(G) For the purposes of this subsection, in the case of any retirement system of the State of Florida, Georgia, Minnesota, North

Dakota, Pennsylvania, Washington, or Hawaii which covers positions of employees of such State who are compensated in whole or in part from grants made to such State under title III, there shall be deemed to be, if such State so desires, a separate retirement system with respect to any of the following:

(i) the positions of such employees;

(ii) the positions of all employees of such State covered by such retirement system who are employed in the department of such State in which the employees referred to in clause (i) are employed; or

(iii) employees of such State covered by such retirement system who are employed in such department of such State in positions other than those referred to in clause (i).

(7) The certification by the governor (or an official of the State designated by him for the purpose), required under paragraph (3) shall be deemed to have been made, in the case of a division or part (created under subparagraph (C) of paragraph (6) or the corresponding provision of prior law) consisting of the positions of members of a retirement system who desire coverage under the agreement under this section, if the governor (or the official so designated) certifies to the Secretary of Health, Education, and Welfare that—

(A) an opportunity to vote by written ballot on the question of whether they wish to be covered under an agreement under this section was given to all individuals who were members of such system at the time the vote was held;

(B) not less than ninety days' notice of such vote was given to all individuals who were members of such system on the date the notice was issued;

(C) the vote was conducted under the supervision of the governor or an agency or individual designated by him; and

(D) such system was divided into two parts or divisions in accordance with the provisions of subparagraphs (C) and (D) of paragraph (6) or the corresponding provision of prior law.

For purposes of this paragraph, an individual in a position to which the State agreement already applied or in a position excluded by or pursuant to paragraph (5) shall not be considered a member of the retirement system.

(8)(A) Notwithstanding paragraph (1), if under the provisions of this subsection an agreement is, after December 31, 1958, made applicable to service performed in positions covered by a retirement system, service performed by an individual in a position covered by such a system may not be excluded from the agreement because such position is also covered under another retirement system.

(B) Subparagraph (A) shall not apply to service performed by an individual in a position covered under a retirement system if such individual, on the day the agreement is made applicable to service performed in positions covered by such retirement system, is not a member of such system and is a member of another system.

(C) If an agreement is made applicable, prior to 1959, to service in positions covered by any retirement system, the preceding provisions of this paragraph shall be applicable in the case of such system if the agreement is modified to so provide.

(D) Except in the case of agreements with the States named in subsection (p) and agreements with interstate instrumentalities, noth-

ing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

Payments and Reports by States

(e)(1) Each agreement under this section shall provide—

(A) that the State will pay to the Secretary of the Treasury, at such time or times as the Secretary of Health, Education, and Welfare may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if the services of employees covered by the agreement constituted employment as defined in section 3121 of such Code; and

(B) that the State will comply with such regulations relating to payments and reports as the Secretary of Health, Education, and Welfare may prescribe to carry out the purposes of this section.

(2) Where—

(A) an individual in any calendar year preforms services to which an agreement under this section is applicable (i) as the employee of two or more political subdivisions of a State or (ii) as the employee of a State and one or more political subdivisions of such State; and

(B) such State provides all of the funds for the payment of those amounts referred to in paragraph (1)(A) which are equivalent to the taxes imposed by section 3111 of the Internal Revenue Code of 1954 with respect to wages paid to such individual for such services; and

(C) the political subdivision or subdivisions involved do not reimburse such State for the payment of such amounts or, in the case of services described in subparagraph (A)(ii), for the payment of so much of such amounts as is attributable to employment by such subdivision or subdivisions;

then, notwithstanding paragraph (1), the agreement under this section with such State may provide (either in the original agreement or by a modification thereof) that the amounts referred to in paragraph (1)(A) may be computed as though the wages paid to such individual for the services referred to in clause (A) of this paragraph were paid by one political subdivision for services performed in its employ; but the provisions of this paragraph shall be applicable only where such State complies with such regulations as the Secretary may prescribe to carry out the purposes of this paragraph. The preceding sentence shall be applicable with respect to wages paid after an effective date specified in such agreement or modification, but in no event with respect to wages paid before (i) January 1, 1957, in the case of an agreement or modification which is mailed or delivered by other means to the Secretary before January 1, 1962, or (ii) the first day of the year in which the agreement or modification is mailed or delivered by other means to the Secretary, in the case of an agreement or modification which is so mailed or delivered on or after January 1, 1962.

Effective Date of Agreement

(f)(1) Except as provided in subsection (e)(2), any agreement or modification of an agreement under this section shall be effective with

respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is agreed to by the Secretary and the State.

(2) In the case of service performed by members of any coverage group—

(A) to which an agreement under this section is made applicable, and

(B) with respect to which the agreement, or modification thereof making the agreement so applicable, specifies an effective date earlier than the date of execution of such agreement and such modification, respectively,

the agreement shall, if so requested by the State, be applicable to such services (to the extent the agreement was not already applicable) performed before such date of execution and after such effective date by any individual as a member of such coverage group if he is such a member on a date, specified by the State, which is earlier than such date of execution, except that in no case may the date so specified be earlier than the date such agreement or such modification, as the case may be, is mailed, or delivered by other means, to the Secretary.

Termination of Agreement

(g) (1) Upon giving at least two years' advance notice in writing to the Secretary of Health, Education, and Welfare, a State may terminate, effective at end of a calendar quarter specified in the notice, its agreement with the Secretary either—

(A) in its entirety, but only if the agreement has been in effect from its effective date for not less than five years prior to the receipt of such notice; or

(B) with respect to any coverage group designated by the State, but only if the agreement has been in effect with respect to such coverage group for not less than five years prior to the receipt of such notice.

(2) If the Secretary, after reasonable notice and opportunity for hearing to a State with whom he has entered into an agreement pursuant to this section, finds that the State has failed or is no longer legally able to comply substantially with any provision of such agreement or of this section, he shall notify such State that the agreement will be terminated in its entirety, or with respect to any one or more coverage groups designated by him, at such time, not later than two year from the date of such notice, as he deems appropriate, unless prior to such time he finds that there no longer is any such failure or that the cause for such legal inability has been removed.

(3) If any agreement entered into under this section is terminated in its entirety, the Secretary and the State may not again enter into an agreement pursuant to this section. If any such agreement is terminated with respect to any coverage group, the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such coverage group.

Deposits in Trust Fund; Adjustments

(h)(1) All amounts received by the Secretary of the Treasury under an agreement made pursuant to this section shall be deposited in the [Trust Funds in the ratio in which amounts are appropriated to such Funds pursuant to subsections (a)(3) and (b)(1) of section 201] *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.*

(2) If more or less than the correct amount due under an agreement made pursuant to this section is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be prescribed by regulations of the Secretary of Health, Education, and Welfare.

(3) If an overpayment cannot be adjusted under paragraph (2), the amount thereof and the time or times it is to be paid shall be certified by the Secretary of Health, Education, and Welfare to the Managing Trustee, and the Managing Trustee, through the Fiscal Service of the Treasury Department and prior to any action thereon by the General Accounting Office, shall make payment in accordance with such certification. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary of Health, Education, and Welfare.

Regulations

(i) Regulations of the Secretary of Health, Education, and Welfare to carry out the purposes of this section shall be designed to make the requirements imposed on States pursuant to this section the same, so far as practicable, as those imposed on employers pursuant to this title and chapter 21 and subtitle F of the Internal Revenue Code of 1954.

Failure To Make Payments

(j) In case any State does not make, at the time or times due, the payments provided for under an agreement pursuant to this section, there shall be added, as part of the amounts due, interest at the rate of 6 per centum per annum from the date due until paid, and the Secretary of Health, Education, and Welfare may, in his discretion deduct such amounts plus interest from any amounts certified by him to the Secretary of the Treasury for payment to such State under any other provision of this Act. Amounts so deducted shall be deemed to have been paid to the State under such other provision of this Act. Amounts equal to the amounts deducted under this subsection are hereby appropriated to the Trust Funds in the ratio in which amounts are deposited in such Funds pursuant to subsection (h)(1).

Instrumentalities of Two or More States

(k)(1) The Secretary of Health, Education, and Welfare may, at the request of any instrumentality of two or more States, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such instrumentality. Such agreement, to

the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

(2) In the case of any instrumentality of two or more States, if—

(A) employees of such instrumentality are in positions covered by a retirement system of such instrumentality or of any of such States or any of the political subdivisions thereof, and

(B) such retirement system is (on, before, or after the date of enactment of this paragraph) divided into two divisions or parts, one of which is composed of positions of members of such system who are employees of such instrumentality and who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who are employees of such instrumentality and who do not desire such coverage, and

(C) it is provided that there shall be included in such division or part composed of the positions of members desiring such coverage the positions of employees of such instrumentality who become members of such system after such coverage is extended,

then such retirement system shall, if such instrumentality so desires, be deemed to be a separate retirement system with respect to each such division or part. An individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection, be regarded as a member of such system. Coverage under the agreement of any such individual shall be provided under the same conditions, to the extent practicable, as are applicable in the case of the States to which the provisions of subsection (d)(6)(C) apply. The position of any employee of any such instrumentality which is covered by any retirement system to which the first sentence of this paragraph is applicable shall, if such individual is ineligible to become a member of such system on the date of enactment of this paragraph or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title. Services in positions covered by a separate retirement system created pursuant to this subsection (and consisting of the positions of members who desire coverage under an agreement under this section) shall be covered under such agreement on compliance, to the extent practicable, with the same conditions as are applicable to coverage under an agreement under this section of services in positions covered by a separate retirement system created pursuant to subparagraph (C) of subsection (d)(6) or the corresponding provision of prior law (and consisting of the positions of members who desire coverage under such agreement).

(3) Any agreement with any instrumentality of two or more States entered into pursuant to this Act may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), apply to service performed by employees of such instrumentality in any policeman's or fireman's position covered by a retirement system, but only upon compliance, to the extent practicable, with the requirements of subsection (d)(3). For the purpose of the preceding sentence, a retirement system which covers positions of policemen or firemen or both, and other positions shall, if the in-

strumentality concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Delegation of Functions

(l) The Secretary of Health, Education, and Welfare is authorized, pursuant to agreement with the head of any Federal agency, to delegate any of his functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

Wisconsin Retirement Fund

(m)(1) Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provisions of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund.

(2) All employees in positions covered by the Wisconsin retirement fund at any time or or after January 1, 1951, shall, for the purposes of subsection (c) only, be deemed to be a separate coverage group; except that there shall be excluded from such separate coverage group all employees in positions to which the agreement applies without regard to this subsection.

(3) The modification pursuant to this subsection shall exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) service performed by any individual during any period before he is included under the Wisconsin retirement fund.

(4) The modification pursuant to this subsection shall, if the State of Wisconsin requests it, exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) all service performed in policemen's positions, all service performed in firemen's positions, or both.

Certain Positions No Longer Covered by Retirement Systems

(n) Notwithstanding subsection (d), an agreement with any State entered into under this section prior to the date of the enactment of this subsection may, prior to January 1, 1958, be modified pursuant to subsection (c)(4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on such date of enactment), in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of the enactment of this subsection, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

Certain Employees of the State of Utah

(o) Notwithstanding the provisions of subsection (d), the agreement with the State of Utah entered into pursuant to this section may be

modified pursuant to subsection (c)(4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950.

Policemen and Firemen in Certain States

(p) Any agreement with the State of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, or Washington entered into pursuant to this section prior to the date of enactment of this subsection may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsection (d)(1) and (d)(3), be modified pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after the date of the enactment of this subsection, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Time Limitation on Assessments

(q)(1) Where a State is liable for an amount due under an agreement pursuant to this section, such State shall remain so liable until the Secretary is satisfied that the amount due has been paid to the Secretary of the Treasury.

(2) Notwithstanding paragraph (1), a State shall not be liable for an amount due under an agreement pursuant to this section, with respect to the wages paid to individuals, after the expiration of the latest of the following periods—

(A) three years, three months, and fifteen days after the year in which such wages were paid, or

(B) three years after the date on which such amount became due, or

(C) three years, three months, and fifteen days after the year following the year in which this subsection is enacted.

unless prior to the expiration of such period the Secretary makes an assessment of the amount due.

(3) For purposes of this subsection and section 205(c), an assessment of an amount due is made when the Secretary mails or otherwise delivers to the State a notice stating the amount he has determined to

be due under an agreement pursuant to this section and the basis for such determination.

(4) An assessment of an amount due made by the Secretary after the expiration of the period specified in paragraph (2) shall nevertheless be deemed to have been made within such period if—

(A) before the expiration of such period (or, if it has previously been extended under this paragraph, of such period as so extended), the State and the Secretary agree in writing to an extension of such period (or extended period) and, subject to such conditions as may be agreed upon, the Secretary makes the assessment prior to the expiration of such extension; or

(B) within the 365 days immediately preceding the expiration of such period (or extended period) the State pays to the Secretary of the Treasury less than the correct amount due under an agreement pursuant to this section with respect to wages paid to individuals in any calendar quarters as members of a coverage group, and the Secretary of Health, Education, and Welfare makes the assessment, adjusted to take into account the amount paid by the State, no later than the 365th day after the day the State made payment to the Secretary of the Treasury; but the Secretary of Health, Education, and Welfare, shall make such assessment only with respect to the wages paid to such individuals in such calendar quarters as members of such coverage group; or

(C) pursuant to subparagraph (A) or (B) of section 205(c)(5) he includes in his records an entry with respect to wages for an individual, but only if such assessment is limited to the amount due with respect to such wages and is made within the period such entry could be made in such records under such subparagraph.

(5) If the Secretary allows a claim for a credit or refund of an overpayment by a State under an agreement pursuant to this section, with respect to wages paid or alleged to have been paid to an individual in a calendar year for services as a member of a coverage group, and if as a result of the facts on which such allowance is based there is an amount due from the State, with respect to wages paid to such individual in such calendar year for services performed as a member of a coverage group, for which amount the State is not liable by reason of paragraph (2) then notwithstanding paragraph (2) the State shall be liable for such amount due if the Secretary makes an assessment of such amount due at the time of or prior to notification to the State of the allowance of such claim. For purposes of this paragraph and paragraph (6), interest as provided for in subsection (j) shall not be included in determining the amount due.

(6) The Secretary shall accept wage reports filed by a State under an agreement pursuant to this section or regulations of the Secretary thereunder, after the expiration of the period specified in paragraph (2) or such period as extended pursuant to paragraph (4), with respect to wages which are paid to individuals performing services as employees in a coverage group included in the agreement and for payment in connection with which the State is not liable by reason of paragraph (2), only if the State—

(A) pays to the Secretary of the Treasury the amount due under such agreement with respect to such wages, and

(B) agrees in writing with the Secretary of Health, Education and Welfare to an extension of the period specified in para-

graph (2) with respect to wages paid to all individuals performing services as employees in such coverage group in the calendar quarters designated by the State in such wage reports as the periods in which such wages were paid. If the State so agrees, the period specified in paragraph (2), or such period as extended pursuant to paragraph (4), shall be extended until such time as the Secretary notifies the State that such wage reports have been accepted.

(7) Notwithstanding the preceding provisions of this subsection, where there is an amount due by a State under an agreement pursuant to this section and there has been a fraudulent attempt on the part of an officer or employee of the State or any political subdivision thereof to defeat or evade payment of such amount due, the State shall be liable for such amount due without regard to the provisions of paragraph (2), and the Secretary may make an assessment of such amount due at any time.

Time Limitation on Credits and Refunds

(r) (1) No credit or refund of an overpayment by a State under an agreement pursuant to this section with respect to wages paid or alleged to have been paid to an individual as a member of a coverage group in a calendar quarter shall be allowed after the expiration of the latest of the following periods—

(A) three years, three months, and fifteen days after the year in which occurred the calendar quarter in which such wages were paid or alleged to have been paid, or

(B) three years after the date the payment which included such overpayment became due under such agreement with respect to the wages paid or alleged to have been paid to such individual as a member of such coverage group in such calendar quarter, or

(C) two years after such overpayment was made to the Secretary of the Treasury, or

(D) three years, three months, and fifteen days after the year following the year in which this subsection is enacted,

unless prior to the expiration of such period a claim for such credit or refund is filed with the Secretary of Health, Education, and Welfare by the State.

(2) A claim for a credit or refund filed by a State after the expiration of the period specified by paragraph (1) shall nevertheless be deemed to have been filed within such period if—

(A) before the expiration of such period (or, if it has previously been extended under this subparagraph, of such period as so extended) the State and the Secretary agree in writing to an extension of such period (or extended period) and the claim is filed with the Secretary by the State prior to the expiration of such extension; but any claim for a credit or refund valid because of this subparagraph shall be allowed only to the extent authorized by the conditions provided for in the agreement for such extension, or

(B) the Secretary deletes from his records an entry with respect to wages of an individual pursuant to the provisions of subparagraph (A), (B), or (E) of section 205(c)(5), but only with respect to the entry so deleted.

Review by Secretary

(s) Where the Secretary has made an assessment of an amount due by a State under an agreement pursuant to this section, disallowed a State's claim for a credit or refund of an overpayment under such agreement, or allowed a State a credit or refund of an overpayment under such agreement, he shall review such assessment, disallowance, or allowance if a written request for such review is filed with him by the State within 90 days (or within such further time as he may allow) after notification to the State of such assessment, disallowance, or allowance. On the basis of the evidence obtained by or submitted to the Secretary, he shall render a decision affirming, modifying, or reversing such assessment, disallowance, or allowance. In notifying the State of his decision, the Secretary shall state the basis therefor.

Review by Court

(t) (1) Notwithstanding any other provision of this title any State, irrespective of the amount in controversy, may file, within two years after the mailing to such State of the notice of any decision by the Secretary pursuant to subsection (s) affecting such State, or within such further time as the Secretary may allow, a civil action for a redetermination of the correctness of the assessment of the amount due, the disallowance of the claim for a refund or credit, or the allowance of the refund or credit, as the case may be, with respect to which the Secretary has rendered such decision. Such action shall be brought in the district court of the United States for the judicial district in which is located the capital of such State, or, if such action is brought by an instrumentality of two or more States, the principal office of such instrumentality. The judgment of the court shall be final, except that it shall be subject to review in the same manner as judgments of such court in other civil actions. Any action filed under this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(2) Notwithstanding the provisions of section 2411 of title 28, United States Code, no interest shall accrue to a State after final judgment with respect to a credit or refund of an overpayment made under an agreement pursuant to this section.

(3) The first sentence of section 2414 of title 28, United States Code, shall not apply to final judgments rendered by district courts of the United States in civil actions filed under this subsection. In such cases, the payment of amounts due to States pursuant to such final judgments shall be adjusted in accordance with the provisions of this section and with regulations promulgated by the Secretary.

Sec. 219. [Repealed.]

Disability Provisions Inapplicable if Benefit Rights Impaired

Sec. 220. None of the provisions of this title relating to periods of disability shall apply in any case in which their application would result in the denial of monthly benefits or a lump-sum death payment which would otherwise be payable under this title; nor shall they apply in the case of any monthly benefit or lump-sum death payment under this title if such benefit or payment would be greater without their application.

Disability Determinations

Sec. 221. (a) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 216(i) or 223(c)) and of the day such disability began, and the determination of the day on which such disability ceases, shall, except as provided in subsection (g), be made by a State agency pursuant to an agreement entered into under subsection (b). Except as provided in subsections (c) and (d), any such determination shall be the determination of the Secretary for purposes of this title.

(b) The Secretary shall enter into an agreement with each State which is willing to make such an agreement under which the State agency or agencies administering the State plan approved under the Vocational Rehabilitation Act, or any other appropriate State agency or agencies, or both, will make the determinations referred to in subsection (a) with respect to all individuals in such State, or with respect to such class or classes of individuals in the State as may be designated in the agreement at the State's request, *other than individuals referred to in subsection (g)(4)*.

(c) The Secretary may on his own motion review a determination, made by a State agency pursuant to an agreement under this section, that an individual is under a disability (as defined in section 216(i) or 223(c)) and, as a result of such review, may determine that such individual is not under a disability (as so defined) or that such disability began on a day later than that determined by such agency, or that such disability ceased on a day earlier than that determined by such agency.

(d) Any individual dissatisfied with any determination under subsection (a), (c), or (g) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(e) Each State which has an agreement with the Secretary under this section shall be entitled to receive from the Trust Funds, in advance or by way of reimbursement, as may be mutually agreed upon, the cost to the State of carrying out the agreement under this section. The Secretary shall from time to time certify such amount as is necessary for this purpose to the Managing Trustee, reduced or increased, as the case may be, by any sum (for which adjustment hereunder has not previously been made) by which the amount certified for any prior period was greater or less than the amount which should have been paid to the State under this subsection for such period; and the Managing Trustee, prior to audit or settlement by the General Accounting Office, shall make payment from the Trust Funds at the time or times fixed by the Secretary, in accordance with such certification. Appropriate adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to the payments made under this subsection shall be made in accordance with paragraph (1) of subsection (g) of section 201 (but taking into account any refunds under subsection (f) of this section) to insure that the Federal Disability Trust Fund is charged with all expenses incurred which are attributable to the administration of section 223 and the Federal Old-Age and Survivors Insurance Trust Fund is charged with all other expenses.

(f) All money paid to a State under this section shall be used solely for the purposes for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Funds.

[(g) In the case of individuals in a State which has no agreement under subsection (b), in the case of individuals outside the United States, and in the case of any class or classes of individuals not included in an agreement under subsection (b), the determinations referred to in subsection (a) shall be made by the Secretary in accordance with regulations prescribed by him.]

(g) In the case of—

(1) individuals in a State which has no agreement under subsection (b),

(2) individuals outside the United States,

(3) any class or classes of individuals not included in an agreement under subsection (b), and

(4) any individual with respect to whom the Secretary, in accordance with regulations prescribed by him, finds that a determination of disability or of the day on which a disability ceased may be made (A) on the evidence furnished by or on behalf of such individual from sources of information as to examination and treatment which are designated by such individual, or (B) on the evidence of remunerative work activities performed by such individual,

the determinations referred to in subsection (a) shall be made by the Secretary in accordance with regulations prescribed by him.

Rehabilitation Services

Referral for Rehabilitation Services

Sec. 222. (a) It is hereby declared to be the policy of the Congress that disabled individuals applying for a determination of disability, and disabled individuals who are entitled to child's insurance benefits shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.

Costs of Rehabilitation Services From Trust Funds

(b) (1) For the purpose of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 223, or

(B) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

to the end that savings will result to the Trust Funds as a result of rehabilitating the maximum number of such individuals into productive activity, there are authorized to be transferred from the Trust Funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals (including (i) services during their waiting periods, and (ii) so much

of the expenditures for the administration of any State plan as is attributable to carrying out this subsection); except that the total amount so made available pursuant to this subsection in any fiscal year may not exceed 1 percent of the benefits under section 202(d) for children who have attained age 18 and are under a disability or under section 223, which were certified for payment in the preceding year. The selection of individuals (including the order in which they shall be selected) to receive such services shall be made in accordance with criteria formulated by the Secretary which are based upon the effect the provision of such services would have upon the Trust Funds.

(2) In the case of each State which is willing to do so, such vocational rehabilitation services shall be furnished under a State plan for vocational rehabilitation services which—

(A) has been approved under section 5 of the Vocational Rehabilitation Act,

(B) provides that, to the extent funds provided under this subsection are adequate for the purpose, such services will be furnished, to any individual in the State who meets the criteria prescribed by the Secretary pursuant to paragraph (1), with reasonable promptness and in accordance with the order of selection determined under such criteria, and

(C) provides that such services will be furnished to any individual without regard to (i) his citizenship or place of residence, (ii) his need for financial assistance except as provided in regulations of the Secretary in the case of maintenance during rehabilitation, or (iii) any order of selection followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

(3) In the case of any State which does not have a plan which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

(4) Payments under this subsection may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

(5) Money paid from the Trust Funds under this subsection to pay the costs of providing services to individuals who are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid out from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

(A) the total cost of the services provided under this subsection, and

(B) subject to the provisions of the preceding sentence, the amount of such cost which should be charged to each of such Trust Funds.

(6) For the purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited

in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection.

Deductions on Account of Refusal To Accept Rehabilitation Services

[(*b*)](*c*) (1) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefit or benefits under sections 202 and 223 for any month in which such individual, if a child who has attained the age of eighteen and is entitled to child's insurance benefits or if an individual entitled to disability insurance benefits refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act. Any individual who is a member or adherent of any recognized church or religious sect which teaches its members or adherents to rely solely, in the treatment and cure of any physical or mental impairment, upon prayer or spiritual means through the application and use of the tenets or teachings of such church or sect, and who, solely because of his adherence to the teachings or tenets of such church, or sect, refuses to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act, shall, for the purposes of the first sentence of this subsection, be deemed to have done so with good cause.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled or from any mother's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or such mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual who is entitled to disability insurance benefits and in which such individual refuses to accept rehabilitation services and a deduction, on account of such refusal, is imposed under paragraph (1). If both this paragraph and paragraph (3) are applicable to a child's insurance benefit for any month, only an amount equal to such benefit shall be deducted.

(3) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to disability insurance benefits, to which a wife, *divorced wife*, husband, or child is entitled, until the total of such deductions equals such wife's, husband's or child's insurance benefit or benefits under section 202 for any month in which the individual, on the basis of whose wages and self-employment income such benefit was payable, refuses to accept rehabilitation services and deductions, on account of such refusal, are imposed under paragraph (1).

(*4*) *The provisions of paragraph (1) shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).*

Period of Trial Work

[(c)] (*d*) (1) The term "period of trial work," with respect to an individual entitled to benefits under section 223 or 202(d), means a period of months beginning and ending as provided in paragraphs (3) and (4).

(2) For purposes of sections 216(i) and 223, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 202(d) who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following the month in which this paragraph is enacted; and no such period may begin for an individual in a period of disability of such individual in which he had a previous period of trial work.

(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(A) the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

(B) the month in which his disability (as defined in section 223(c)(2)) ceases (as determined after application of paragraph (2) of this subsection).

(5) In the case of an individual who becomes entitled to benefits under section 223 for any month as provided in clause (ii) of subsection (a)(1) of such section, the preceding provisions of this subsection shall not apply with respect to services in any month beginning with the first month for which he is so entitled and ending with the first month thereafter for which he is not entitled to benefits under section 223.

Disability Insurance Benefit Payments

Disability Insurance Benefits

Sec. 223. (a)(1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

(B) has not attained the age of sixty-five, *and*

(C) has filed application for disability insurance benefits, [and]

[(D) is under a disability (as defined in subsection (c)(2)), at the time such application is filed,]

shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(3)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216 (i)) which ceased, within the sixty-month period preceding the first month in which he is under such disability, and

ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains age 65, the first month for which he is entitled to old-age insurance benefits, or the third month following the month in which his disability ceases.

(2) [Such] *Except as provided in section 202(q), such* individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained age 62 (if a woman) or age 65 (if a man) in—

(A) the first month of his waiting period, or

(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits.

and as though he had become entitled to old-age insurance benefits in the month in which he filed his application for disabiliy insurance benefits *and was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit.* For the purposes of the preceding sentence, in the case of a woman who [both was fully insured and had] attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b)(3) shall not include the [first year] *year* in which she [both was fully insured and had] attained age 62, or any year thereafter.

[(3) If, for any month before the month in which an individual attains age 65, such individual is entitled to—

[(A) a widow's, widower's, or parent's insurance benefit, or

[(B) an old-age, wife's, or husband's insurance benefit which is reduced under subsection (q) of section 202,

such individual may not, for any month after the first month for which such individual is so entitled, become entitled to disability insurance benefits; and a period of disability may not begin with respect to such individual in any month after such first month.]

Filing of Application

(b) [No application for disability insurance benefits shall be accepted as a valid application for purposes of this section (1) if it is filed more than nine months before the first month for which the applicant becomes entitled to such benefits, or (2) in any case in which clause (ii) of paragraph (1) of subsection (a) is applicable, if it is filed more than six months before the first month for which the applicant becomes entitled to such benefits; and any application filed within such nine months' period or six months' period, as the case may be, shall be deemed to have been filed in such first month.] *An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If, upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.* [An individual who would have been entitled to a disability insurance benefit for any month after June 1957 had he filed application therefor prior to the

end of such month shall be entitled to such benefit for such month if he is continuously under a disability after such month and until he files application therefor, and he files such application prior to the end of the twelfth month immediately succeeding such month.] *An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month if he files such application before the end of the 12th month immediately succeeding such month.*

Definitions

(c) For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 (if a woman) or age 65 (if a man) and filed application for benefits under section 202(a) on the first day of such month, and

(B) he had not less than twenty quarters of coverage during the forty-quarter period ending with the quarter in which such first day occurred, not counting as part of such forty-quarter period any quarter any part of which was inincluded in a period of disability (as defined in section 216(i)) unless such quarter was a quarter of coverage.

[(2) The term "disability" means in ability 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 under a disability unless he furnishes such proof of the existence thereof as may be required.]

(2) The term "disability" means inability 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 which has lasted or can be expected to last for a continuous period of not less than 12 calendar months. An individual shall not be considered to be under a disability unless he furnishes such proof of the existence thereof as may be required.

(3) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of six consecutive calendar months—

(A) throughout which the individual who files such application has been under a disability [which continues until such application is filed], and

(B)(i) which begins not earlier than the first day of the eighteenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such eighteenth month, or (ii) if he is not so insured in such month, which begins not earlier than with the first day of the first month after such eighteenth month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

Reduction of Benefits Based on Disability on Account of Receipt of Workmen's Compensation

Sec. 224. (*a*) *If any month prior to the month in which an individual attains the age of 62—*

(*1*) *such individual is entitled to benefits under section 223, and*

(*2*) *such individual is entitled for such month, under a workmen's compensation law or plan of the United States or a State, to periodic benefits for a total or partial disability (whether or not permanent), and the Secretary has, in a prior month, received notice of such entitlement for such month.*

the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(*3*) *such total of benefits under sections 223 and 202 for such month and*

(*4*) *such periodic benefits payable (and actually paid) for such month to such individual under the workmen's compensation law or plan,*

exceeds the higher of—

(*5*) *80 per centum of his "average current earnings", or*

(*6*) *the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section.*

In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month reduce such total below the sum of—

(*7*) *the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and*

(*8*) *any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduc- determined if all of them had been so entitled in such first month), and*

For purposes of clause (5), an individual's average current earnings means the larger of (A) the average monthly wage used for purposes of computing his benefits under section 223, or (B) one-sixtieth of the total of his wages and self-employment income for the five consecutive calendar years after 1951 for which such wages and self-employment income were highest.

(*b*) *If any periodic benefit under a workmen's compensation law or plan is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate as nearly as practicable the reduction prescribed by subsection (a).*

(c) *Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 203, but before deductions under such section and under section 222(b).*

(d) *The reduction of benefits required by this section shall not be made if the workmen's compensation law or plan under which a periodic benefit is payable provides for the reduction thereof when any one is entitled to benefits under this title on the basis of the wages and self-employment income of an individual entitled to benefits under section 223.*

(e) *If it appears to the Secretary that an individual may be eligible for periodic benefits under a workmen's compensation law or plan which would give rise to reduction under this section, he may require, as a condition of certification for payment of any benefits under section 223 to any individual for any month and of any benefits under section 202 for such month based on such individual's wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Secretary may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205(i).*

(f)(1) *In the second calendar year after the year in which reduction under this section in the total of an individual's benefit under section 223 and any benefits under section 202 based on his wages and self-employment income was first required (in a continuous period of months), and in each third year thereafter, the Secretary shall redetermine the amount of such benefits which are still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this title on the basis of such individual's wages and self-employment income. Such redetermined benefit shall be determined as of, and shall become effective with, the January following the year in which such redetermination was made.*

(2) *In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of his average current earnings as initially determined under subsection (a) and the ratio of (i) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which such redetermination is made, to (ii) the average of the taxable wages of such persons reported to the Secretary for the first calendar quarter of the taxable year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability). Any amount determined under the preceding sentence which is not a multiple of $1 shall be reduced to the next lower multiple of $1.*

(g) *Whenever a reduction in the total of benefits for any month based on an individual's wages and self-employment income is made under this section, each benefit, except the disability insurance benefit, shall first be proportionately decreased, and any excess of such reduction over the sum of all such benefits other than the disability insurance benefit shall then be applied to such disability insurance benefit.*

Suspension of Benefits Based on Disability

Sec. 225. If the Secretary, on the basis of information obtained by or submitted to him, believes that an individual entitled to benefits under section 223, or that a child who has attained the age of eighteen and is entitled to benefits under section 202(d), may have ceased to be under a disability, the Secretary may suspend the payment of benefits under such section 223 or 202(d) until it is determined (as provided in section 221) whether or not such individual's disability has ceased or until the Secretary believes that such disability has not ceased. In the case of any individual whose disability is subject to determination under an agreement with a State under section 221(b), the Secretary shall promptly notify the appropriate State of his action under this section and shall request a prompt determination of whether such individual's disability has ceased. For purposes of this section, the term "disability" has the meaning assigned to such term in section 223(c)(2). Whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 202, on the basis of the wages and self-employment income of such individual, shall be suspended for such month. *The first sentence of this section shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).*

Entitlement to Hospital Insurance Benefits

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

[(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.]

(2) an individual shall be deemed to be entitled to monthly insurance benefits under section 202 for the month in which he died if he would have been entitled to such benefits for such month had he died in the next 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 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)] (c) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

Transitional Insured Status

Sec. 227. (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in so much of paragraph (1) of section 214(a) as follows clause (C) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 202(a), and of his wife to benefits under section 202(b), but, in the case of such wife, only if she attains the age of 72 before 1969 and only with respect to wife's insurance benefits under section 202(b) for and after the month in which she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of his old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be $35 and the amount of the wife's insurance benefit of his wife shall, notwithstanding the provisions of section 202(b), be $17.50.

(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose widow attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in so much of paragraph (1) thereof as follows clause (C) shall, for purposes of determining her entitlement to widow's insurance benefits under section 202(e), instead be—

(1) 3 quarters of coverage if such widow attains the age of 72 in or before 1966,

(2) 4 quarters of coverage if such widow attains the age of 72 in 1967, or

(3) 5 quarters of coverage if such widow attains the age of 72 in 1968.

The amount of her widow's insurance benefit for each month shall, notwithstanding the provisions of 202(e) (and section 202(m)), be $35.

(c) In the case of any individual who becomes, or upon filing application therefor would become, entited to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose widow attains the age of 72 before 1969, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such widow to widow's insurance benefits under section 202(e).

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

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State Plans for Aid and Services to Needy Families With Children

Sec. 402. (a) A State plan for aid and services to needy families with children 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; (3) 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; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with dependent children is denied or is not acted upon with reasonable promptness; (5) provide such methods of administration (including after January 1, 1940, 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan; and (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 correctnes and verification of such reports; (7) provide that the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (*A*) *the State agency may disregard not more than $50 per month of earned income of each dependent child under the age of 18 but not in excess of three in the same home, and* (*B*) the State agency may, subject to limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child; (8) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to families with dependent children; (9) provide, effective July 1, 1951, that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall be furnished

with reasonable promptness to all eligible individuals; (10) effective July 1, 1952, provide for prompt notice to appropriate law-enforcement officials of the furnishing of aid to families with dependent children in respect of a child who has been deserted or abandoned by a parent; (11) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act; (12) provide a description of the services (if any) which the State agency makes available to maintain and strengthen family life for children, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (13) provide for the development and application of a program for such welfare and related services for each child who receives aid to families with dependent children as may be necessary in the light of the particular home conditions and other needs of such child, and provide for coordination of such programs, and any other services provided for children under the State plan, with the child-welfare services plan developed as provided in part 3 of title V, with a view toward providing welfare and related services which will best promote the welfare of such child and his family.

(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 aid to families with dependent children, a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

Payment to States

Sec. 403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to families with dependent children under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof)—

(A) [fourteen-seventeenths] *five-sixths* of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of [$17] *$18* multiplied by the total number of recipients of aid to families with dependent children for such month (which total number, for purposes of this subsection, means (i) the number of individuals with respect to whom such aid in the form of money payments is paid for such month, plus (ii) the number of other individuals with respect to whom expenditures were

made in such month as aid to families with dependent children in the form of medical or any other type of remedial care, plus (iii) the number of individuals, not counted under clause (i) or (ii), with respect to whom payments described in section 406(b)(2) are made in such month and included as expenditures for purposes of this paragraph or paragraph (2)); plus

(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of [$30] *$32* multiplied by the total number of recipients of aid to families with dependent children for such month; and

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to families with dependent children under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof) not counting so much of any expenditure with respect to any month as exceeds $18 multiplied by the total number of recipients of such aid for such month; and

(3) in the case of any State whose State plan approved under section 402 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to any relative, specified in section 406(a), with whom any dependent child (applying for or receiving aid to families with dependent children) is living in order to help such relative attain or retain capability for self-support or self-care, or services which are so prescribed and so provided in order to maintain and strengthen family life for any such child, or

(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to any such child or relative, or

(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for any relative specified in section 406(a) with whom any child (who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of aid to families with dependent children) is living, or as appropriate for such a child, if such services are requested by such relative and are provided to such relative or child in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to any relative, specified in section 406(a), with whom any child (who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of aid to families with dependent children) is living, or to such child, if such services are requested by such relative or for services so provided to any child who is an applicant for or recipient of such aid, or to any relative, specified in section 406(a), with whom such a child is living; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(4) in the case of any State whose plan approved under section 402 does not meet the requirements of subsection (c)(1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.

The number of individuals with respect to whom payments described in section 406(b)(2) are made for any month, who may be included as recipients of aid to families with dependent children for purposes of paragraph (1) or (2), may not exceed 5 per centum of the number of other recipients of aid to families with dependent children for such month.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection 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, (B) records showing the number of dependent children in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to aid to families with dependent children furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

(c)(1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 402 must provide that the State agency shall make available at least those services to maintain and strengthen family life for children, and to help relatives specified in section 406(a) with whom children (who

are applicants for or recipients of aid to families with dependent children) are living to attain or retain capability for self-support or self-care, which are prescribed by the Secretary.

(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragarph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.

* * * * * * *

Definitions

Sec. 406. When used in this title—

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen or (B) under the age of twenty-one and (as determined in accordance with standards prescribed by the Secretary) a student regularly [attending a high school in pursuance of a course of study leading to a high school diploma or its equivalent] *attending a school, college, or university*, or regularly attending a course of vocational or technical training designed to fit him for gainful employment;

(b) The term "aid to families with dependent children" means money payments with respect to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, a dependent child or dependent children, and includes (1) money payments or medical care or any type of remedial care recognized under State law to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section

407), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's spouse, with whom such child is living) which do not meet the preceding requirements of this subsection, but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child and relative, but only with respect to a State whose State plan approved under section 402 includes provision for—

(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2);

(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to families with dependent children to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(C) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

(D) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary;

(E) aid in the form of foster home care in behalf of children described in section 408(a); and

(F) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made;

(c) The term "relative with whom any dependent child is living" means the individual who is one of the relatives specified in subsection (a) and with whom such child is living (within the meaning of such subsection) in a place of residence maintained by such individual (himself or together with any one or more of the other relatives so specified) as his (or their) own home.

TITLE V—GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

Part 1—Maternal and Child Health Services

Appropriation

Section 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress the following sums are hereby authorized to be appropriated: $25,000,000 for the fiscal year ending June 30, 1963, $30,000,000 for the fiscal year ending June 30, 1964, $35,000,000 for the fiscal year ending June 30, 1965, [$40,000,000 each for the fiscal year ending June 30, 1966, and the succeeding fiscal year, $45,000,000 each for the fiscal year ending June 30, 1968, and the succeeding fiscal year, and $50,000,000 each for the fiscal year ending June 30, 1970, and succeeding fiscal years.] *$45000,000 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 each for fiscal year ending June 30, 1970, and succeeding fiscal years.* 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 such services.

* * * * *

Approval of State Plans

Sec. 503. (a) A State plan for maternal and child-health services must (1) provide for financial participation by the State; (2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; (3) provide such methods of administration (including after January 1, 1940, 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) as are necessary for the proper and efficient operation of the plan; (4) provide that the State health 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 he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for the extension and improvement of local maternal and child-health services administered by local child-health units; (6) provide for cooperation with medical, nursing, and welfare groups and organizations; [and] (7) provide for the development of demonstration services in needy areas and among groups in special need *; and (8) effective July 1, 1967, provide 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.*

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the State health agency of his approval.

Payment to States

Sec. 504. (a) From the sums appropriated therefor and the allotments available under section 502(a), the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection 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 one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

(c) The Secretary of Health, Education, and Welfare shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under secion 502(b), and the Secretary of the Treasury shall, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Health, Education, and Welfare. Payments of grants for special projects under section 502(b) may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants.

(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.

* * * * * * *

Part 2—Services for Crippled Children

Appropriation

Sec. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, the following sums are hereby authorized to be appropriated: $25,000,000 for the fiscal year ending June 30, 1963, $30,000,000 for the fiscal year ending June 30, 1964, $35,000,000 for the fiscal year ending June 30, 1965, [$40,000,000 each for the fiscal year ending June 30, 1966, and the succeeding fiscal year, $45,000,000 each for the fiscal year ending June 30, 1968, and the succeeding fiscal year, and $50,000,000 each for the fiscal year ending June 30, 1970, and succeeding fiscal years.] *$45,000,000 for the fiscal year ending June 30, 1966, $50,000,000 for the fiscal year ending June 30, 1967, $55,000,000 for the fiscal year ending June 30, 1968, $55,000,000 for the fiscal year ending June 30, 1969, and $60,000,000 each for the fiscal year ending June 30, 1970, and succeeding fiscal years.* 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 such services.

* * * * * * *

Approval of State Plans

Sec. 513. (a) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (including after January 1, 1940, 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) as are necessary for the proper and efficient operation of the plan; (4) 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 he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for carrying out the purposes specified in section 511; [and] (6) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children; *and* (7) *effective*

July 1, 1967, provide 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.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the State agency of his approval.

Payments to States

Sec. 514. (a) From the sums appropriated therefor and the allotments available under section 512(a), the Secretary of the Treasury shall pay to each State, which has an approved plan for services for crippled children for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection 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 one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (b) such investigation as he may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State at the time or times fixed by the Secretary of Health, Education, and Welfare the amount so certified.

(c) The Secretary of Health, Education, and Welfare shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotment available under section 512 (b), and the Secretary of the Treasury shall, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Health, Education, and Welfare. Payments of grants for special projects under [section 512(b)] *section 512(b) or 516* may be made in

advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants.

(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

***Sec. 516.** There are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1967, $10,000,000 for the fiscal year ending June 30, 1968, and $17,500,000 for each fiscal year thereafter, for grants by the Secretary to public or other nonprofit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.*

Part 3—Child-Welfare Services

Appropriation

Sec. 521. For the purpose of enabling the United States, through the Secretary, to cooperate with State public-welfare agencies in establishing, extending, and strenthening child welfare services, the following sums are hereby authorized to be appropriated: $25,000,000 each for the fiscal year ending June 30, 1961, and the succeeding fiscal year, $30,000,000 for the fiscal year ending June 30, 1963, $35,000,000 for the fiscal year ending June 30, 1964, [$40,000,00 each for the fiscal year ending June 30, 1965, and the succeeding fiscal year, $45,000,000 each for the fiscal year ending June 30, 1967, and the succeeding fiscal year, and $50,000,000 each for the fiscal year ending June 30, 1969, and succeeding fiscal years] *$40,000,000 for the fiscal year ending June 30, 1965, $45,000,000 for the fiscal year ending June 30, 1966, $5,000,000 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 each year for the fiscal year ending June 30, 1970, and succeeding fiscal years.*

Allotments to States

[**Sec. 522.** (a) All but $10,000,000 of the total appropriated for a fiscal year under section 521, or, if such total is less than $35,000,000, all but the excess (if any) of such total over $25,000,000, shall be allotted by the Secretary for use by cooperating State public-welfare agencies which have plans developed jointly by the State agency and the Secretary, as follows: He shall allot to each State $70,000 or, if the amount appropriated under section 521 for such year is less than $25,000,000, he shall allot to each State $50,000 or, if greater, such portion of $70,000 as the amount appropriated under such section bears to $25,000,000; and he shall allot to each State an amount which bears the

same ratio to the remainder of the sum available for allotment under this subsection for such year as the product of (1) the population of such State under the age of 21 and (2) the allotment percentage of such State (as determined under section 524) bears to the sum of the corresponding products of all the State.

[(b)(1) If the amount allotted to a State under subsection (a) for any fiscal year is less than such State's base allotment, it shall be increased to such base allotment, the total of the increases thereby required being derived by proportionately reducing the amount allotted under subsection (a) to each of the remaining States, but with such adjustments as may be necessary to prevent the allotment of any such remaining State under subsection (a) from being thereby reduced to less than its base allotment.

[(2) For purposes of paragraph (1) the base allotment of any State for any fiscal year means the amount which would be allotted to such State for such year under the provisions of section 521, as in effect prior to the enactment of the Social Security Amendments of 1958, as applied to an appropriation of $12,000,000.]

Sec. 522. *The sum appropriated pursuant to section 521 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary, as follows: He shall allot $70,000 to each State, and shall allot to each State an amount which bears the same ratio to the remainder of the sum so appropriated for such year as the product of (1) the population of such State under the age of 21 and (2) the allotment percentage of such State (as determined under section 524) bears to the sum of the corresponding products of all the States.*

Payment to States

Sec. 523. (a) From the sums appropriated therefor and the allotment available under this part, the Secretary shall from time to time pay to each State—

(1) that has a plan for child-welfare services which has been developed as provided in this part and which—

(A) provides for coordination between the services provided under such plan and the services provided for dependent children under the State plan approved under title IV, with a view to provision of welfare and related services which will best promote the welfare of such children and their families, and

(B) provides with respect to day care services (including the provision of such care) provided under the plan—

(i) for cooperative arrangements with the State health authority and the State agency primarily responsible for State supervision of public schools to assure maximum utilization of such agencies in the provision of necessary health services and education for children receiving day care,

(ii) for an advisory committee, to advise the State public welfare agency on the general policy involved in the provision of day care services under the State plan, which shall include among its members representatives of other State agencies concerned with day care or serv-

ices related thereto and persons representative of professional or civic or other public or nonprofit private agencies, organizations, or groups concerned with the provision of day care,

(iii) for such safeguards as may be necessary to assure provision of day care under the plan only in cases in which it is in the best interest of the child and the mother and only in cases in which it is determined, under criteria established by the State, that a need for such care exists; and, in cases in which the family is able to pay part or all of the costs of such care, for payment of such fees as may be reasonable in the light of such ability, and

(iv) for giving priority, in determining the existence of need for such day care, to members of low-income or other groups in the population and to geographical areas which have the greatest relative need for extension of such day care, [and]

(v) that day care provided under the plan will be provided only in facilities (including private homes) which are licensed by the State, or approved (as meeting the standards established for such licensing) by the State agency responsible for licensing facilities of this type, and

(2) that makes a satisfactory showing that the State is extending the provision of child-welfare services in the State, with priority being given to communities with the greatest need for such services after giving consideration to their relative financial need, and with a view to making available by July 1, 1975, in all political subdivisions of the State, for all children in need thereof, child-welfare services provided by the staff (which shall to the extent feasible be composed of trained child-welfare personnel) of the State public welfare agency or of the local agency participating in the administration of the plan in the political subdivision,

an amount equal to the Federal share (as determined under section 524) of the total sum expended under such plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child-welfare services, in developing State services for the encouragement and assistance of adequate methods of community child-welfare organization, in paying the costs of returning any runaway child who has not attained the age of eighteen to his own community in another State, and of maintaining such child until such return (for a period not exceeding fifteen days), in cases in which such costs cannot be met by the parents of such child or by any person, agency, or institution legally responsible for the support of such child: *Provided*, That in developing such services for children the facilities and experience of voluntary agencies shall be utilized in accordance with child-care programs and arrangements in the States and local communities as may be authorized by the State.

* * * * * * *

[Day Care

[Sec. 527. (a) In order to assist the States to provide adequately for the care and protection of children whose parents are, for part of

the day, working or seeking work, or otherwise absent from the home or unable for other reasons to provide parental supervision, the portion of the appropriation under section 521 for any fiscal year which is not allotted under section 522 shall be allotted by the Secretary among the States solely for use, under the State plan developed as provided in this part, for day care services, including the provision of day care in facilities (including private homes) which are licensed by the State, or are approved (as meeting the standards established for such licensing) by the State agency responsible for licensing facilities of this type, as follows: He shall allot to each State an amount which bears the same ratio to such portion of the appropriation as the product of (1) the population of the State under the age of 21 and (2) the allotment percentage of such State (as determined under section 524) bears to the sum of the corresponding products of all the States, except that the allotment of any State as so computed which is less than $10,000 shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotments to each of the remaining States (as so computed) having an allotment in excess of that amount, but with such adjustments as may be necessary to prevent the allotment of any of such remaining States from being thereby reduced to less than that amount.

[(b) The amount of any allotment to a State under subsection (a) for any fiscal year which the State certifies to the Secretary will not be required for the purposes for which allotted shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out such purposes for sums in excess of those previously allotted to them under subsection (a), and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the need for additional funds in carrying out such purposes, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one, and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under subsection (a).]

* * * * * * *

[Part 4—Grants for Special Maternity and Infant Care Projects and Research Projects]

Part 4—Grants for Special Maternity and Infant Care Projects, for Projects for Health of School and Preschool Children, and for Research Projects

Special Project Grants for Health of School and Preschool Children

Sec. 532. *(a) In order to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, there are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1966, $35,000,000 for the fiscal year ending June 30, 1967, $45,000,000 for the fiscal year ending June 30, 1968, $50,000,000 for the fiscal year ending June 30, 1969, and*

$55,000,000 for the fiscal year ending June 30, 1970, for grants as provided in this section.

(b) From the sums appropriated pursuant to subsection (a), the Secretary is authorized to make grants to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 513, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 per centum of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). No project shall be eligible for a grant under this subsection unless it provides (1) for the coordination of health care and services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare, and education programs for such children, (2) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) of inpatient hospital services provided under the project, and (3) that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and no such project for children and youth of school age shall be considered to be of a comprehensive nature for purposes of this subsection unless it includes (subject to the limitation in the preceding provisions of this sentence) at least such screening, diagnosis, preventive services, treatment, correction of defect, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

(c) From the sums appropriated pursuant to subsection (a), the Secretary is also authorized to make grants to the State health agency, the State mental health agency, and the State public welfare agency of any State and (with the consent of such State health, mental health, or public welfare agency) to the health agency, mental health agency, and public welfare agency, respectively, of any political subdivision of the State, and to any public or nonprofit private agency or institution to pay not to exceed 75 per centum of the cost of projects providing for the identification (with a view to providing for as early identification as possible), care, and treatment of children who are, or are in danger of becoming, emotionally disturbed, including the followup of children receiving such care or treatment. No project shall be eligible for a grant under this subsection unless it provides for coordination of the care and treatment provided under it with, and utilization (to the extent feasible) of, community mental health centers and other State or local agencies engaged in health, welfare, or education programs or activities for such children.

(d) Payments of grants under this section may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine.

Research Projects Relating to Maternal and Child Health Services and Crippled Children's Services

Sec. [532.] *533.* (a) There are authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1964, such sums, not exceeding $8,000,000 for any fiscal year, as the Congress may determine to enable the Secretary to make grants to or jointly financed cooperative arrangements with public or other nonprofit institutions of higher learning, and public or other nonprofit agencies and organizations engaged in research or in maternal and child health or crippled children's programs, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof.

(b) Payments of grants or under contracts or cooperative arrangements under this section may be made (after necessary adjustment, in the case of grants, on account of previously made underpayments or overpayments) in advance or by way of reimbursements, and in such installments and on such conditions, as the Secretary may determine.

TITLE VII—ADMINISTRATION

* * * * * * *

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.

(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.

(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.

(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 busi-

ness, 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—

(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.

TITLE X—GRANTS TO STATES FOR AID TO THE BLIND

* * * * * * *

Payment to States

Sec. 1003. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to the blind under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof)—

(A) [29/35] *31/37* of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of [$35] *$37* multiplied by the total number of recipients of aid to the blind for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received aid to the blind in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the blind in the form of medical or any other type of remedial care); plus

(B) the Federal percent of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure

with respect to any month, as exceeds the project of [$70] *$75* multiplied by the total number of such receipients of aid to the blind for such month; and

(2) in the case of Pureto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the blind for such month; and

(3) in the case of any State whose State plan approved under section 1002 meets the requirements of subsection (c)(1) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind to help them attain or retain capability for self-support or self-care, or

(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants, or recipients, or

(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the blind, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the

political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervision the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(4) in the case of any State whose State plan approved under section 1002 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection, 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, (B) records showing the number of blind

individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the blind furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1002 must provide that the State agency shall make available to applicants for or recipients of aid to the blind at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.

* * * * * * *

Definition

Sec. 1006. For the purpose of this title, the term "aid to the blind" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, blind individuals who are needy, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medial institution) or any individual [(a) who is a patient in an institution for tuberculosis or mental diseases,, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof] *who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1002 includes provision for—*

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

TITLE XI—GENERAL PROVISIONS

Definitions

Section 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles I, IV, V, VII, X, XI, XIV [and XVI] *XVI, and XIX* includes the Virgin Islands and Guam.

(2) The term "United States" when used in a geographical sense means, except where otherwise provided, the States.

(3) The term "person" means an individual, a trust or estate, a partnership, or a corporation.

(4) The term "corporation" includes associations, joint-stock companies, and insurance companies.

(5) The term "shareholder" includes a member in an association, joint-stock company, or insurance company.

(6) The term "Secretary", except when the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(7) The terms "physician" and "medical care" and "hospitalization" include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

(8) (A) The "Federal percentage" for any State (other than Puerto Rico, the Virgin Islands, and Guam) shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States; except that the Federal percentage shall in no case be less than 50 per centum or more than 65 per centum.

(B) The Federal percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Secretary shall promulgate such percentage as soon as possible after the enactment of the Social Security Amendments of 1958, which promulgation shall be conclusive for each of the eleven quarters in the period beginning October 1, 1958, and ending with the close of June 30, 1961.

(C) The term "United States" means (but only for purposes of subparagraphs (A) and (B) of this paragraph) the fifty States and the District of Columbia.

(D) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the "United States". Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

(b) The terms "includes" and "including" when used in a definition contained in this Act shall not be deemed to exclude other things otherwise within the meaning of the term defined.

(c) Whenever under this Act or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct

any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this Act the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

(d) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

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Disclosure of Information in Possession of Department

Sec. 1106. (a) No disclosure of any return or portion of a return (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act or under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, or under chapter 2 or 21 or, pursuant thereto, under subtitle F of the Internal Revenue Code of 1954, or under regulations made under authority thereof, which has been transmitted to the Secretary of Health, Education, and Welfare by the Commissioner of Internal Revenue, or of any file, record, report, or other paper, or any information, obtained at any time by the Secretary or by any officer or employee of the Department of Health, Education, and Welfare in the course of discharging the duties of the Secretary under this Act, and no disclosure of any such file, record, report, or other paper, or information, obtained at any time by any person from the Secretary or from any officer or employee of the Department of Health, Education, and Welfare, shall be made except as the Secretary may by regulations prescribe. Any person who shall violate any provision of this section shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

(b) Requests for information, disclosure of which is authorized by regulations prescribed pursuant to subsection (a) of this section, and requests for services, may, subject to such limitations as may be prescribed by the Secretary to avoid undue interference with his functions under this Act, be complied with if the agency, person, or organization making the request agrees to pay for the information or services requested in such amount, if any (not exceeding the cost of furnishing the information or services), as may be determined by the Secretary. Payments for information or services furnished pursuant to this section shall be made in advance or by way of reimbursement as may be requested by the Secretary, and shall be deposited in the Treasury as a special deposit to be used to reimburse the appropriations (including authorizations to make expenditures from the Federal Old-Age and Survivors Insurance Trust Fund [and the Federal Disability Insurance Trust Fund], *the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund*) for the unit or units of the Department of Health, Education, and Welfare which furnished the information or services.

* * * * * * *

Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam

Sec. 1108. The total amount certified by the Secretary of Health, Education, and Welfare under title I (other than section 3(a)(3) thereof), IV, X, XIV, and XVI (other than section 1603(a)(3) thereof) for payment to Puerto Rico with respect to any fiscal year shall not exceed [$9,800,000, of which $625,000 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)] *$9,800,000*; the total amount certified by the Secretary under such titles for payments to the Virgin Islands with respect to any fiscal year shall not exceed [$330,000, of which $18,750 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)] *$330,000;* and the total amount certified by the Secretary under such titles for payment to Guam with respect to any fiscal year shall not exceed [$450,000, of which $25,000 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)] *$450,000.* Notwithstanding the provisions of sections 502(a)(2), 512(a)(2), [522(a), and 527(a)] *522(a)* and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial [(or, in the case of section 527(a), the minimum)] allotment specified in such sections, allot such smaller amounts to Guam as he may deem appropriate.

Earned Income of Blind Recipients

Sec. 1109. [Notwithstanding the provisions of sections 2(a)(10)(A), 402(a)(7), 1002(a)(8), 1402(a)(8), and 1602(a)(14), a State plan approved under title I, IV, X, XIV, or XVI may until June 30, 1954, and thereafter shall provide that where earned income has been disregarded in determining the need of an individual receiving aid to the blind under a State plan approved under title X, the earned income so disregarded (but not in excess of the amount specified in section 1002(a)(8)) shall not be taken into consideration in determining the need of any other individual for assistance under a State plan approved under title I, IV, X, XIV, or XVI.] *Any amount which is disregarded (or set aside for future needs) in determining 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.*

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Medical Care Guides and Reports for Public Assistance and Medical Assistance [for the Aged]

Sec. 1112. In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this Act and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use

of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance [for the aged]; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section.

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Demonstration Projects

Sec. 1115. In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, IV, X, XIV, [or XVI] *XVI, or XIX* in a State or States—

(a) the Secretary may waive compliance with any of the requirements of section 2, 402, 1002, 1402, [or 1602] *1602, or 1902*, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(b) costs of such project which would not otherwise be included as expenditures under section 3, 403, 1003, 1403, [*or 1603*] *1603, or 1903* as the case may be, and which are not included as part of the costs or projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate.

In addition, not to exceed $2,000,000 of the aggregate amount appropriated for payments to States under such titles for any fiscal year ending prior to July 1, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such titles and is not included as part of the cost of projects for purposes of section 1110.

Administrative and Judicial Review of Certain Administrative Determinations

Sec. 1116. *(a) (1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, IV, X, XIV, XVI, or XIX, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.*

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such

hearing is furnished to such State, unless the Secretary and such State agree in writing to hold the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 1004, 1404, 1604, or 1904 may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be worthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(b) For the purposes of subsection (a), any amendment of a State plan approved under title I, IV, X, XIV, XVI, or XIX may, at the option of the State, be treated as the submission of a new State plan.

(c) Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title I, IV, X, XIV, XVI, or XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

Maintenance of State Effort

Sec. 1117. *(a) The total of the amounts determined under sections 3, 403, 1003, 1403, 1603, and 1903 for any State for any quarter beginning after December 31, 1965, and ending before July 1, 1969, shall be reduced to the extent that—*

(1) the excess of (A) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, 1603, and 1903 for such quarter over (B) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, and 1603 for the same quarter of the fiscal year ending June 30, 1965, is greater than

(2) the excess of (A) the total of the expenditures for such quarter (for which the determination is being made) under the

plans of the State approved under titles I, IV, X, XIV, XVI, and XIX over (B) the total of the expenditures under the State plans of the State approved under titles I, IV, X, XIV, and XVI for the same quarter of the fiscal year ending June 30, 1965;

except that, at the option of the State, any of the following may be substituted (with respect to the quarters of any fiscal year) for the amount determined as provided in paragraph (1)(B)—

(3) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, and 1603 for the same quarter in the fiscal year ending June 30, 1964; or

(4) the average of the totals determined for the State under sections 3, 403, 1003, 1403, and 1603 for each quarter in the fiscal year ending June 30, 1964, or June 30, 1965.

If the substitution of the total referred to in paragraph (3) is chosen by the State, there shall be substituted for the amount determined under clause (B) of paragraph (2) the total of the expenditures under the plans of the State approved under titles I, IV, X, XIV, and XVI for the quarter referred to in such paragraph (3). If the substitution of the average for either of the years referred to in paragraph (4) is chosen by the State, there shall be substituted for the amount determined under clause (B) of paragraph (2) the average of the total expenditures under the plans of the State approved under titles I, IV, X, XIV, and XVI for each quarter in the same fiscal year.

(b) For the purposes of this section, expenditures under the plans of any State approved under titles I, IV, X, XIV, XVI, and XIX and the reduction determined with respect thereto under this section, shall be determined on the basis of data furnished by the State in the quarterly reports submitted by the State to the Secretary pursuant to and in accordance with the requirements of the Secretary under title I, IV X, XIV, XVI, or XIX; and determinations so made shall be conclusive for purposes of this section.

(c) If a reduction is required under the preceding provisions of this section in the total of the amounts determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 for any quarter, the Secretary shall determine which of such amounts shall be reduced and the extent thereof in such manner as in his judgment will best carry out the purpose of maintaining State effort under the Federal-State public assistance programs of the State, and with the total of such reductions to be equal to the reduction required under subsections (a) and (b) of this section.

TITLE XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

* * * * * * *

State Plans for Aid to the Permanently and Totally Disabled

Sec. 1402. (a) A State plan for aid to the permanently and totally disabled 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; (3) 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; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness; (5) 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan; (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 that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act, aid to families with dependent children under the State plan approved under section 402 of this Act, or aid to the blind under the State plan approved under section 1002 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled, as well as any expenses reasonably attributable to the earning of any such income; *except that, in making such determination, (A) of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (B) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation;* (9) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to the permanently and totally disabled; (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; (11) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; and (12) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services.

(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 aid to the permanently and totally disabled under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

(2) Any citizenship requirement which excludes any citizen of the United States.

Payments to States

Sec. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to the permanently and totally disabled under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof)—

(A) [29/35] *31/37* of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of [$35] *$37* multiplied by the total number of recipients of aid to the permanently and totally disabled for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received aid to the permanently and totally disabled in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the permanently and totally disabled in the form of medical or any other type of remedial care); plus

(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of [$70] *$75* multiplied by the total number of such recipients of aid to the permanently and totally disabled for such month; and

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the permanently and totally disabled for such month; and

(3) in the case of any State whose State plan approved under section 1402 meets the requirements of subsection (c)(1), an

amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled to help them attain or retain capability for self-support or self-care, or in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the permanently and totally disabled, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for

vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described by clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(4) in the case of any State whose State plan approved under section 1402 does not meet the requirements of subsection (c)(1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate 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 subsection, 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, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount

expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, and the amount so certified.

(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1402 must provide that the State agency shall make available to applicants for or recipients of aid of the permanently and totally disabled at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

(2) In the case of any State whose plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, unuder paragraph (4) of such subsection.

* * * * * * *

Definition

Sec. 1405. For the purposes of this title, the term "aid to the permanently and totally disabled" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of, needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual [(a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof.] *who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the*

welfare of such needy individual, but only with respect to a State whose State plan approved under section 1402 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the Senate agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED, OR FOR SUCH AID AND MEDICAL ASSISTANCE FOR THE AGED

State Plans for Aid to the Aged, Blind, or Disabled, or for Such Aid and Medical Assistance for the Aged

Sec. 1602. (a) A State plan for aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged, 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;

(3) 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;

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

(5) 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(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 aid or assistance under the plan shall have opportunity to do so, and that such aid or assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes aid or assistance to or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) provide a description of the services (if any) which the State agency makes available to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(11) provide that no aid or assistance will be furnished any individual under the plan with respect to any period with respect to which he is receiving assistance under the State plan approved under title I or aid under the State plan approved under title IV, X, or XIV;

(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) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of aid or assistance under the plan;

[(14) provide that the State agency, shall in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual who is blind, the State agency (A) shall disregard the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, and in making such determination with respect to any other individual who has attained age 65 and is claiming aid to the aged, blind, or disabled, of the first $50 per month of earned income the State agency may, after December 31, 1962, disregard not

more than the first $10 thereof plus one-half of the remainder; and]

(14) provide that the State agency shall, in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

(A) if such individual is blind, the State agency (i) shall disregard the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (ii) shall, for a period not in excess of 12 months, and may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan,

(B) if such individual is not blind but is permanently and totally disabled, (i) of the first $80 per month of earned income, the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (ii) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation, and

(C) if such individual has attained age 65 and is neither blind nor permanently and totally disabled, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder; [*and*]

(15) if the State plan includes medical assistance for the aged—

(A) provide for inclusion of some institutional and some noninstitutional care and services;

(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

(C) 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 such assistance to individuals who are residents of the State but are absent therefrom; and

(D) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged 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, after the death of such individual and his surviving spouse, if any, from such individual's estate) of

any medical assistance for the aged correctly paid on behalf of such individual under the plan [.];

(16) if the State plan includes aid or assistance to or 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 periodic 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 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; and

(17) if the State plan includes aid or assistance to or 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.

Notwithstanding paragraph (3), if on January 1, 1962, 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 was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV, the State agency which administered or supervised the administration of such plan approved under title X may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, or diasabled (or for aid to the aged, blind, or disabled and medical assist-

ance for the aged) which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; 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.

(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 aid or assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for aid to the aged, blind, or disabled excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for such aid and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950 were applicable on January 1, 1962, and to which the sentence of section 1002(b) following paragraph (2) thereof is applicable on the date on which its State plan for aid to the aged, blind, or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged) was submitted for approval under this title, the Secretary shall approve the plan of such State for aid to the aged, blind, or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged) for purposes of this title, even though it does not meet the requirements of paragraph (14) of subsection (a), if it meets all other requirements of this title for an approved plan for aid to the aged, blind, or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged); but payments under section 1603 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1603 under a plan approved under this section without regard to the provisions of this sentence.

(c) Subject to the last sentence of subsection (a), nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

Payments to States

Sec. 1603. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended [during such quarter] *during each month of such quarter* aid to the aged, blind, or disabled under the State plan (including expenditures for *premiums*

under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

(A) [29/35] *31/37* of such expenditures, not counting so much of any expenditure with respect to [any month] *such month* any month as exceeds the product of [$35] *$37* multiplied by the total number of recipients of such aid for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received such aid in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care); plus

[(B) the Federal percentage (as defined in section 1101 (a)(8)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of $70 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

[(C) the larger of the following: (i) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (B), not counting so much of any expenditure with respect to any month as exceeds (I) the product of $85 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (II) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of $70 multiplied by such total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of $15 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month;]

(B) the larger of the following:

(i)(I) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month, plus (II) 15 per centum of the total expended during such month as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such months as exceeds the product of $15 multiplied

by the total number of recipients of aid to the aged, blind, or disabled for such month, or

(ii) (I) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditures with respect to such month as exceeds (a) the product of $52 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (b) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of $37 multiplied by such total number of such recipients, plus (II) the Federal percentage of the amount by which the total expended during such month as aid to the aged, blind, or disabled under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B) (ii), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month.

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan (including expenditures for *premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other* insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of $45 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (II) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of $37.50 multipled by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of $7.50 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month;

(3) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 6(c)) of the total amounts expended during such quarter as medical assistance for

the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof); and

(4) in the case of any State whose State plan approved under section 1602 meets the requirements of subsection (c)(1), and amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid or assistance under the plan to help them attain or retain capability for self-support or self-care, or

(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid or assistance under the plan, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid or assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid or assistance; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabiliation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to

agreement under subparagraph (E), if provided by such staff, and

(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(5) in the case of any State whose State plan approved under section 1602 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.

(b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) 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 subsection, 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, in such installments as he may determine, to the State 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 aid or assistance furnished under that State plan, but excluding any amount of such aid or assistance recovered from the estate of a deceased recipient which is not in excess of the amount

expended by the State or any political subdivision thereof for the funeral expenses of the deceased, 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.

(c) (1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 1602 must provide that the State agency shall make available to applicants for or recipients of aid to the aged, blind, or disabled under such State plant at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency, administering or supervising the administration of such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made subject to the other provisions of this title, under paragraph (5) of such subsection.

(d) 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 in the State 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 in the State 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.

* * * * * * *

Definitions

Sec. 1605. [(a) For the purposes of this title, the term "aid to the aged, blind, or disabled" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but does not include—

[(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases, or

[(2) any such payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as the result thereof, or

[(3) any such care in behalf of any individual, who is a patient in a medical institution as a result of a diagnosis that he has tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.]

(a) For purposes of this title, the term "aid to the aged, blind, or disabled" means money payments to, or (of provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(D) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

(b) For purposes of this title, the term "medical assistance for the aged" 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 sixty-five years of age or older and [who are not recipients of aid to the aged, blind, or disabled] *who are not recipients of aid to the aged, blind, or disabled (except, for any month, for recipients of aid to the aged, blind, or disabled who are admitted to or discharged from a medical institution during such month)* but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services;
(2) skilled nursing-home services;
(3) physicians' services;
(4) outpatient hospital or clinic services;
(5) home health care services;
(6) private duty nursing services;
(7) physical therapy and related services;
(8) dental services;
(9) laboratory and X-ray services;
(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(11) diagnostic, screening, and preventive services; and
(12) any other medical care or remedial care recognized under State law;

[except that such term does not include any such payments with respect to—

[(A) care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or

[(B) care or services for any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.]

except that such term does not include 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).

TITLE XVII—GRANTS FOR PLANNING COMPREHENSIVE ACTION TO COMBAT MENTAL RETARDATION

Authorization of Appropriations

Sec. 1701. For the purpose of assisting the States (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) to plan for and take other steps leading to comprehensive State and community action to combat mental retardation, there is authorized to be appropriated the sum of $2,200,000. *There are also authorized to be appropriated, for assisting such States in initiating the implementation and carrying out of planning and other steps to combat mental retardation, $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.*

Grant to States

Sec. 1702. The sums appropriated pursuant to *the first sentence of* section 1701 shall be available for grants to States by the Secretary during the fiscal year ending June 30, 1964, and the succeeding fiscal year*; and the sums appropriated pursuant to the second sentence of such section for the fiscal year ending June 30, 1966, shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year.* Any such grant to a State, which shall not exceed 75 per centum of the cost of the planning and related activities involved, may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED

Prohibition Against Any Federal Interference

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

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

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

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

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 120 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 175 visits (during any 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 subsections (c) and (d)) be made for—

(1) inpatient hospital services (including inpatient psychiatric hospital services and inpatient tuberculosis hospital services) furnished to him during such spell after such services have been furnished to him for 120 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 210 days during his lifetime.

(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 120-day period immediately before such first day shall be included in determining the 120-day limit under subsection (b)(1) with respect to the spell of illness which includes such first day.

(d) Payment under this part may be made for post-hospital home health services furnished an individual only during any one-year period described in section 1861(n) following his most recent hospital or extended care facility discharge which meets the requirements of such

section, and only for the first 175 visits in such periods and after the beginning of one spell of illness and before the beginning of the next. 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.

(e) For purposes of subsections (b), (c), and (d), inpatient 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.

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

Deductibles

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 deduction equal to one-fourth of the inpatient hospital deductible for each day (before the 121st 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] section 226 or under the Railroad Retirement Act of 1937, 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 deduction equal to one-eighth of the inpatient hospital deductible for each day (before the 121st 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 of 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] section 226 or under the Railroad Retirement Act of 1937, 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—*

(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;

(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—

(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;

(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;

(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 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;

(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 could 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;

(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 furnish 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).

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 provided 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.

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 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.

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.

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.*

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 of org nization (subject to such review by the Secretary as may be pro-*

vided 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.

(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless (1) (A) he finds that to do so is consistent with the effective and efficient administration of this part, (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.

(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.

(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.

(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

(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.

(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.

(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).

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—

(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.

(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 Funds;

(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.

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.

(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.

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

(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.

(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, Educa-

tion, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.]

(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).

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 or unless such services are in the field of pathology, radiology, physiatry, or anesthesiology) 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.

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 rea-

sonable 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)).

(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 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 and applied toward such individual's deductible under this section for such preceding year, and except that the amount of any deductible imposed under section 1813(a)(2)(A) with respect to outpatient hospital diagnostic services furnished in any 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.

Duration of Services

Sec. 1834. *(a) Payment under this part may not be made for home health services furnished an individual during any calendar year after such services have been furnished to him during such year for 100 visits. 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 by 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) is a resident of the United States, and is (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 10 years immediately preceding the month in which he applies for enrollment under this part,

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 begin 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 July 1, 1966, the initial general enrollment period shall begin on April 1, 1966, and shall end on September 30, 1966.

(d) In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 on or after July 1, 1966, his initial enrollment 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 even-numbered year beginning with 1968.

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) January 1, 1967; 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.

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.

Amounts of Premiums

Sec. 1839. *(a) The monthly premium of each individual enrolled under this part for each month before 1969 shall be $3.*

(b)(1) The monthly premium of each individual enrolled under this part for each month after 1968 shall be the amount determined under paragraph (2).

(2) The Secretary shall, between July 1 and October 1 of 1968 and of each even-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.

(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.

(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.

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.*

(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.

(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.

(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 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 amout 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 (other than 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.

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—

(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.

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 Managaing 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.

(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.

(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.

(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.] 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 have been recovered under subsection (g) of section 21 of the Railroad Retirement Act of 1937.

(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).

(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

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 opportunity 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.

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.*

(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, 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.

(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) January 1, 1967;

(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

(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.

(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).

(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

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.*

(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 1968 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 January 1967 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

(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 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.

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 (other than services provided in the field of pathology, radiology, physiatry, or anesthesiology); and

(5) the serivces 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.

Inpatient Psychiatric Hospital Services

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

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;

(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 hopsital 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.

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 instiution which meets the requirements of pararaphs (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.

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 necesary 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.

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 Commision on the 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.

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;

(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 (1)), 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

(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 such individual shall be deemed not to have been discharged from the 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

(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 (1)) 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;

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 (or a distinct part of an institution) which is operated, or listed and certified, as a Christian Science nursing home by the First Church of Christ, Scientist, in Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such an institution to in-patients, and payment may be made with respect to services provided by or in such an institution only to the 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.

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 ths 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 vent 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 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.

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.

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

(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.

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;

(7) 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 prescribed in regulations. The term "home health agency" also includes a Christian Science visiting nurse service operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such a visiting nurse service to individuals, and payment may be made with respect to services provided by such visiting nurse service only to the 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.

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 furnishd 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.

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

(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 continguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone.

Medical and Other Health Services

(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) (A) physicians' services;
(B) chiropractors' services; and
(C) podiatrists' 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 physicians' 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 and 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 (1) such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homoeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or (2) combinations of drugs or biologicals if the principal ingredient or ingredients of the combinations meet the conditions specified in clause (1), or (3) such drugs or biologicals 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 "privider 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 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 acccommodations 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.

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.

Chiropractors' and Podiatrists' Services

(y) (1) The term "chiropractor" means an individual who is licensed under State law to practice as a chiropractor in the State; and the term "chiropractors' services" means services performed by a chiropractor within the scope of his license.

(2) The term "podiatrist" means an individual who is licensed under State law to practice as a podiatrist in the State; and the term "podiatrists' service" means services performed by a podiatrist within the scope of his license.

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 given 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 work-

men'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 (subject, in the case of hospitals, to the limitation provided in section 1861(e)(8)) higher requirements for such State than for other States.*

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

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.*

(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.

Effect of Accreditation

Sec. 1865. *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 the Accreditation of Hospitals. If such Commission, as 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

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.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction imposed pursuant to section 1813(a)(1), (a)(2), or (a)(4) or section 1833(b) 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 (or may be) 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.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expen-

sive 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.

(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.

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.

(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.

(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 decisions 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 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

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 representatiev 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.

National Medical Review Committee

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.

(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.

(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.

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.*

(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 $1,000 or more, shall be entitled to a hearing thereon by the Secretary 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).

(c) Any institution or agency dissatisfied with any determination by the Secertary 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).

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 the Secretary finds that—

(1) more than the correct amount of payment has been made 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 adjustment or recovery shall be made with respect to the amount in excess of the correct amount, under regulations prescribed [(after consultation with the Railroad Retirement Board)] by the Secretary, by (A) decreasing any payment under title II of this Act [or under the Railroad Retirement Act of 1937, as the case may be,] to which such individual is entitled, or (B) requiring such individual or his estate to refund the amount in excess of the correct amount, or (C) decreasing any payment under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, payable to the estate of such individual or to any other person on the basis of the wages and self-employment income [(or compensation)] which were the basis of the payments to such individual, or (D) by applying any combination of the foregoing. As soon as practicable after any such adjustment or recovery 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 Retire-

ment Act of 1937)] *the amount of the overpayment as to which the adjustment or recovery is to be made.*

(c) There shall be no adjustment as provided in subsection (b) of payments (including payments under section 1814(e)) to, or recovery as provided in such subsection by the United States from, any person who is without fault if such adjustment or recovery would defeat the purposes of title II of this Act [*or of the Railroad Retirement Act of 1937, as the case may be,*] *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 tile II.*

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.*

Administration

Sec. 1874. *(a)* [*Except as otherwise provided in this title, the insurance programs established by this title shall be administered by the Secretary.*] *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. 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.*

(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.

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.*

(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.

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;

(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) (A) 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; and

(B) provide that, after June 30, 1967, the requirements under the standards established and maintained by such authority or authorities shall include any requirements which may be contained in standards established by the Secretary relating to protection against fire and other hazards to the health and safety of individuals in such private or public institutions;

(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 (except as to care and services described in paragraph (4) or (14) of section 1905(a)) 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, provided (except as to care and services described in paragraph (4) or (14) of section 1905 (a))—

(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;

(11) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation service 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 appplication 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;

(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 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 provisons of secton 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 per-

sonnel, 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 (on or before the first day of the calendar quarter following the 40-calendar quarter period beginning with the first calendar quarter for which the plan is effective) 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, except for section 406(a)(2), are (or would, if needy, be) dependent children under title IV (and are under the age of 21) or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 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 and dental services for individuals under the age of 21;

(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) skilled nursing home services and dental services for other individuals;

(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 in an institution for tuberculosis or mental disease; 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.

SOCIAL SECURITY AMENDMENTS OF 1960

(Act of September 13, 1960)

State and Local Governmental Employees

Sec. 102. * * *

* * * * * * *

Certain Employees in the State of California

(k)(*1*) Notwithstanding any provision of section 218 of the Social Security Act, the agreement with the State of California heretofore entered into pursuant to such section may at the option of such State be modified, at any time prior to 1962, pursuant to subsection (c)(4) of such section 218, so as to apply to services performed by any individual who, on or after January 1, 1957, and on or before December 31, 1959, was employed by such State (or any political subdivision thereof) in any hospital employee's portion which, on September 1, 1954, was covered by a retirement system, but which, prior to 1960, was removed from coverage by such retirement system if, prior to July 1, 1960, there have been paid in good faith to the Secretary of the Treasury, with respect to any of the services performed by such idividual in any such position, amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed. Notwithstanding the provisions of subsection (f) of such section 218 such modification shall be effective with respect to (1) all services performed by such individual in any such position on or after January 1, 1960, and (2) all such services, performed before such date, with respect to which amounts equivalent to such taxes have, prior to the date of enactment of this subsection, been paid.

(*2*) *Such agreement, as modified pursuant to paragraph (1), may at the option of such State be further modified, at any time prior to the seventh month after the month in which this paragraph is enacted, so as to apply to services performed for any hospital affected by such earlier modification by any individual who after December 31, 1959, is or was employed by such State (or any political subdivision thereof) in any position described in paragraph (1). Such modification shall be effective with respect to (A) all services performed by such individual in any such position on or after January 1, 1962, and (B)*

all such services, performed before such date, with respect to which amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed have, prior to the date of the enactment of this paragraph, been paid.

* * * * * * *

Employees of Nonprofit Organizations

Sec. 105. [(b)(1) If—

[(A) an individual performed service in the employ of an organization after 1950 with respect to which remuneration was paid before July 1, 1960, and such service is expected from employment under section 210(a)(8)(B) of the Social Security Act.

[(B) such service would have constituted employment as defined in section 210 of such Act if the requirements of section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) were satisfied,

[(C) such organization paid before August 11, 1960, any amount, as taxes imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 (or corresponding provisions of prior law), with respect to such remuneration paid by the organization to the individual for such service,

[(D) such individual (or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act)) requests that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, and

[(E) the request is made in such form and manner, and with such official, as may be prescribed by regulations made by the Secretary of Health, Education, and Welfare,

then, subject to the conditions stated in paragraphs (2), (3), and (4), the remuneration with respect to which the amount has been paid as taxes shall be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act.

[(2) Paragraph (1) shall not apply with respect to an individual unless the organization referred to in paragraph (1)(A)—

[(A) on or before the date on which the request described in paragraph (1) is made, has filed a certificate pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law), or

[(B) no longer has any individual in its employ for remuneration at the time such request is made.

[(3) Paragraph (1) shall not apply with respect to an individual who was in the employ of the organization referred to in paragraph (2)(A) at any time during the 24-month period following the calendar quarter in which the certificate was filed, unless the organization paid an amount as taxes under sections 3101 and 3111 of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) with respect to remuneration paid by the organization to the employee during some portion of such 24-month period.

[(4) If credit or refund of any portion of the amount referred to in paragraph (1)(C) (other than a credit or refund which would

be allowed if the service constituted employment for purposes of chapter 21 of the Internal Revenue Code of 1954) has been obtained, paragraph (1) shall not apply with respect to the individual unless the amount credited or refunded (including any interest under section 6611) is repaid before January 1, 1963.

[(5) If—

[(A) any remuneration for service performed by an individual is deemed pursuant to paragraph (1) to constitute remuneration for employment for purposes of title II of the Social Security Act,

[(B) such individual performs service, on or after the date on which the request is made, in the employ of the organization referred to in paragraph (1)(A), and

[(C) the certificate filed by such organization pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) is not effective with respect to service performed by such individual before the first day of the calendar quarter following the quarter in which the request is made,

then, for purposes of clauses (ii) and (iii) of section 210(a)(8)(B) of the Social Security Act and of clauses (ii) and (iii) of section 3121(b)(8)(B) of the Internal Revenue Code of 1954, such individual shall be deemed to have become an employee of such organization (or to have become a member of a group described in section 3121(k)(1)(E) of such Code) on the first day of the calendar quarter following the quarter in which the request is made.]

(b)(1) If—

(A) an individual performed service in the employ of an organization with respect to which remuneration was paid before the first day of the calendar quarter in which the organization filed a waiver certificate pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954, and such service is excepted from employment under section 210(a)(8)(B) of the Social Security Act,

(B) such service would have constituted employment as defined in section 210 of such Act if the requirements of section 3121(k)(1) of such Code were satisfied,

(C) such organization paid, on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization filed a certificate pursuant to section 3121(k)(1) of such Code, any amount, as taxes imposed by sections 3101 and 3111 of such Code, with respect to such remuneration paid by the organization to the individual for such service,

(D) such individual, or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of such Act), requests that such remuneration be deemed to constitute remuneration for employment for purposes of title II of such Act, and

(E) the request is made in such form and manner, and with such official, as may be prescribed by regulations made by the Secretary of Health, Education, and Welfare,

then, subject to the conditions stated in paragraphs (2), (3), (4), and (5), the remuneration with respect to which the amount has been paid

as taxes shall be deemed to constitute remuneration for employment for purposes of title II of such Act.

(2) Paragraph (1) shall not apply with respect to an individual unless the organization referred to in paragraph (1) (A), on or before the date on which the request described in paragraph (1) is made, has filed a certificate pursuant to section 3121 (k) (1) of such Code.

(3) Paragraph (1) shall not apply with respect to an individual who is employed by the organization referred to in paragraph (2) on the date the certificate is filed.

(4) If credit or refund of any portion of the amount referred to in paragraph (1) (C) (other than a credit or refund which would be allowed if the service constituted employment for purposes of chapter 21 of such Code) has been obtained, paragraph (1) shall not apply with respect to the individual unless the amount credited or refunded (including any interest under section 6611 of such Code) is repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization filed a certificate pursuant to section 3121 (k) (1) of such Code.

(5) Paragraph (1) shall not apply to any service performed for the organization in a period for which a certificate filed pursuant to section 3121 (k) (1) of such Code is not in effect.

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Computations and Recomputations of Primary Insurance Amounts

Sec. 303. * * *

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(g) (1) In the case of any individual who both was fully insured and had attained retirement age prior to 1961 and (A) who becomes entitled to old-age insurance benefits after 1960, or (B) who dies after 1960 without being entitled to such benefits, then, [not withstanding the amendments made by the preceding subsections of this section,] *notwithstanding the amendments made by the preceding subsections of this section, or the amendments made by section 302 of the Social Security Amendments of 1965*, the Secretary shall also compute such individual's primary insurance amount on the basis of such individual's average monthly wage determined under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act with a closing date determined under section 215 (b) (3) (B) of such Act as then in effect, but only if such closing date would have been applicable to such computation had this section not been enacted. If the primary insurance amount resulting from the use of such an average monthly wage is higher than the primary insurance amount resulting from the use of an average monthly wage determined pursuant to the provisions of section 215 of the Social Security Act, as amended by the [Social Security Amendments of 1960,] *Social Security Amendments of 1960, or (if such individual becomes entitled to old-age insurance benefits after 1965, or dies after 1965 without becoming so entitled) as amended by the Social Security Amendments of 1965*, such higher primary insurance amount shall be the individual's primary insurance amount for purposes of such section 215. The terms used in this subsection shall have the meaning assigned to them by title II of the Social Security Act; except that

the terms "fully insured" and "retirement age" shall have the meaning assigned to them by such title II as in effect on September 13, 1960.

(2) Notwithstanding the amendments made by the preceding subsections of this section, in the case of any individual who was entitled (without regard to the provisions of section 223(b) of the Social Security Act) to a disability insurance benefit under such section 223 for the month before the month in which he became entitled to an old-age insurance benefit under section 202(a) of such Act, or in which he died, and such disability insurance benefit was based upon a primary insurance amount determined under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act, the Secretary shall, in applying the provisions of such section 215(a) (except paragraph (4) thereof), for purposes of determining benefits payable under section 202 of such Act on the basis of such individual's wages and self-employment income, determine such individual's average monthly wage under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act. The provisions of this paragraph shall not apply with respect to any such individual, entitled to such old-age insurance benefits, (i) who applies, after 1960, for a recomputation (to which he is entitled) of his primary insurance amount under section 215(f)(2) of such Act, or (ii) who dies after 1960 and meets the conditions for a recomputation of his primary insurance amount under section 215(f)(4) of such Act.

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SOCIAL SECURITY AMENDMENTS OF 1958

(Act of August 28, 1958)

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Teachers in the State of Maine

Sec. 316. For the purposes of any modification which might be made after the date of enactment of this Act and prior to [July 1, 1965,] *July 1, 1970*, by the State of Maine of its existing agreement made under section 218 of the Social Security Act, any retirement system of such State which covers positions of teachers and positions of other employees shall, if such State so desires, be deemed (notwithstanding the provisions of subsection (d) of such section) to consist of a separate retirement system with respect to the positions of such teachers and a separate retirement system with respect to the positions of such other employees; and for the purposes of this sentence, the term "teacher" shall mean any teacher, principal, supervisor, school nurse, school dietitian, school secretary or superintendent employed in any public school, including teachers in unorganized territory.

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SOCIAL SECURITY AMENDMENTS OF 1956

(Act of August 1, 1956)

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Advisory Council on Social Security Financing

Sec. 116. * * *

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[(e) During 1963, 1966, and every fifth year thereafter, the Secretary shall appoint an Advisory Council on Social Security Financing, with the same functions, and constituted in the same manner, as prescribed in the preceding subsections of this section. Each such Council shall report its findings and recommendations, as prescribed in subsection (d), not later than January 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist, and such report and recommendations shall be included in the annual report of the Board of Trustees to be submitted to the Congress not later than the March 1 following such January 1.]

SOCIAL SECURITY AMENDMENTS OF 1954

(Act of September 1, 1954)

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Increase in Benefit Amounts

Sec. 102. * * *

* * * * * * *

(f) * * *

(2) (A) The amendment made by subsection (b) (2) shall be applicable only in the case of monthly benefits for months after August 1954, and the lump-sum death payment in the case of death after August 1954, based on the wages and self-employment income of an individual (i) who does not become eligible for benefits under section 202(a) of the Social Security Act until after August 1954, or (ii) who dies after August 1954, and without becoming eligible for benefits under such section 202(a), or (iii) who is or has been entitled to have his primary insurance amount recomputed under section 215(f) (2) of the Social Security Act, as amended by subsection (e) (2) of this section, or under subsection (e) (5) (B) of this section, or (iv) with respect to whom not less than six of the quarters elapsing after June 1953 are quarters of coverage (as defined in such Act), or (v) who files an application for a disability determination which is accepted as an application for purposes of section 216(i) of such Act, or (vi) who dies after August 1954, and whose survivors are (or would, but for the provisions of section 215(f) (6) of such Act, be) entitled to a recomputation of his primary insurance amount under section 215(f) (4) (A) of such Act, as amended by this Act. For purposes of the preceding sentence an individual shall be deemed eligible for benefits under section 202(a) of the Social Security Act for any month if he was, or

would upon filing application therefor in such month have been, entitled to such benefits for such month.

[(B) In the case of any individual entitled to old-age insurance benefits under section 202(a) of the Social Security Act who was or, upon filing application therefor, would have been entitled to such benefits for August 1954, to whom subparagraph (A) is inapplicable, and with respect to whom not less than six of the quarters elapsing after June 30, 1953, are quarters of coverage, the Secretary of Health, Education, and Welfare shall, notwithstanding the provisions of section 215(f)(1) of the Social Security Act, recompute the primary insurance amount of such individual but only upon the filing of an application, after August 1954, by him or, if he dies without filing such an application, by any person entitled to monthly survivors benefits under section 202 of such Act on the basis of such individual's wages and self-employment income. Such recomputation shall be made in the manner provided in section 215 of the Social Security Act as in effect prior to the enactment of the Social Security Amendments of 1960 for computation of such individual's primary insurance amount, except that the provisions of subsection (f) of such section (other than paragraph (3)(C) thereof) shall not be applicable for purposes of such computation, and except that his closing date, for purposes of subsection (b) of such section, shall be determined as though he became entitled to old-age insurance benefits in the month in which he filed such application for recomputation or, if he died without filing such application, the month in which he died. Such recomputation shall be effective (i) if the application is filed by such individual, for and after the twelfth month before the month in which the application therefor was filed by such individual but in no case before the first month of the quarter which is such individual's sixth quarter of coverage acquired after June 30, 1953, or (ii) if such application was filed by a person entitled to monthly survivors benefits under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income, for and after the first month for which such person was entitled to such survivors benefits. No such recomputation of an individual's primary insurance amount shall be effective unless it results in a higher primary insurance amount for him; nor shall any such recomputation of an individual's primary insurance amount be effective if such amount has previously been recomputed under this subsection.]

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INTERNAL REVENUE CODE OF 1954

SEC. 213. MEDICAL, DENTAL, ETC., EXPENSES

* * * * * * *

(c) DEFINITIONS.—For purposes of this section—

[(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 (including amounts paid for accident or health insurance), or

[(B) for transportation primarily for and essential to medical care referred to in subparagraph (A).]

(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).

[(2)](4) The determination of whether an individual is married at any time during the taxable year shall be made in accordance with the provisions of section 6013(d) (relating to determination of status as husband and wife).

* * * * * * *

(g) MAXIMUM LIMITATION IF TAXPAYER OR SPOUSE [HAS ATTAINED AGE 65 AND] IS DISABLED.—

(1) SPECIAL RULE.—Subject to the provisions of paragraph (2), the deduction under this section shall not exceed—

(A) $20,000, if the taxpayer [has attained the age of 65 before the close of the taxable year and] is disabled, or if his spouse [has attained the age of 65 before the close of the taxable year and] is disabled and if his spouse does not make a separate return for the taxable year, or

(B) $40,000, if both the taxpayer and his spouse [have attained the age of 65 before the close of the taxable year and] are disabled and if the taxpayer files a joint return with his spouse under section 6013.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) amounts paid by the taxpayer during the taxable year for medical care, other than amounts paid for—

(i) his medical care, if he [has attained the age of 65 before the close of the taxable year and] is disabled, or

(ii) the medical care of his spouse, if his spouse [has attained the age of 65 before the close of the taxable year and] is disabled, shall be taken into account only to the extent that such amounts do not exceed the maximum limitation provided in subsection (c) which would (but for the provisions of this subsection) apply to the taxpayer for the taxable year;

(B) if the taxpayer [has attained the age of 65 before the close of the taxable year and] is disabled, amounts paid by him during the taxable year for his medical care shall be taken into account only to the extent that such amounts do not exceed $20,000; and

(C) if the spouse of the taxpayer [has attained the age of 65 before the close of the taxable year and] is disabled, amounts paid by the taxpayer during the taxable year for the medical care of his spouse shall be taken into account only to the extent that such amounts do not exceed $20,000.

(3) MEANING OF DISABLED.—For purpose of paragraph (1), 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.

(4) DETERMINATION OF STATUS.—For purposes of paragraph (1), the determination as to whether the taxpayer or his spouse is disabled shall be made as of the close of the taxable year of the taxpayer, except that if his spouse dies during such taxable year such determination shall be made with respect to his spouse as of the time of such death.

* * * * *

[SEC. 1401. RATE OF TAX.

[In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

[(1) in the case of any taxable year beginning after December 31, 1961, and before January 1, 1963, the tax shall be equal to 4.7 percent of the amount of the self-employment income for such taxable year;

[(2) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5.4 percent of the amount of the self-employment income for such taxable year;

[(3) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to

6.2 percent of the amount of the self-employment income for such taxable year; and

[(4) in the case of any taxable year beginning after December 31, 1967, the tax shall be equal to 6.9 percent of the amount of the self-employment income for such taxable year.]

SEC. 1401. RATE OF TAX.

(a) Old-Age, Survivors, and Disability Insurance.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

(1) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1973, the tax shall be equal to 6.7 percent of the amount of the self-employment income for such taxable year; and

(3) in the case of any taxable year beginning after December 31, 1972, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year.

(b) Hospital Insurance.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

(1) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1967, the tax shall be equal to 0.325 percent of the amount of the self-employment income for such taxable year;

(2) in the case of any taxable year beginning after December 31, 1966, and before January 1, 1971, the tax shall be equal to 0.50 percent of the amount of the self-employment income for such taxable year;

(3) in the case of any taxable year beginning after December 31, 1970, and before January 1, 1973, the tax shall be equal to 0.55 percent of the amount of the self-employment income for such taxable year;

(4) in the case of any taxable year beginning after December 31, 1972, and before January 1, 1976, the tax shall be equal to 0.60 percent of the amount of the self-employment income for such taxable year;

(5) in the case of any taxable year beginning after December 31, 1975, and before January 1, 1980, the tax shall be equal to 0.65 percent of the amount of the self-employment income for such taxable year;

(6) in the case of any taxable year beginning after December 31, 1979, and before January 1, 1987, the tax shall be equal to 0.75 percent of the amount of the self-employment income for such taxable year; and

(7) in the case of any taxable year beginning after December 31, 1986, the tax shall be equal to 0.85 percent of the amount of the self-employment income for such taxable year.

[For purposes of the tax imposed by this subsection, the exclusion of employee representatives by section 1402(c)(3) shall not apply.]

SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT.—

* * * * * * *

(9) the term "possession of the United States" as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) shall be deemed not to include the Virgin Islands, Guam, or American Samoa.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based on the ordinary income or loss of the partnership for any taxable year of the partnership ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 3121(g)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than [$1,800] *$2,400*, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66⅔ percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than [$1,800] *$2,400* and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than [$1,200] *$1,600*, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be [$1,200] *$1,600;* and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is not more than [$1,800] *$2,400*, his distributive share of income described in section 702(a)(9) derived from such trade or business may, at his option, be deemed to be an amount equal to 66⅔ percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is more than [$1,800] *$2,400* and his distributive share (whether or not distributed) of income described in section 702(a)(9) derived from such trade or business (computed under this subsection without regard to this sentence) is less than [$1,200] *$1,600*, his distributive share of income described in section 702(a)(9) derived from such trade or business may, at his option, be deemed to be [$1,200] *$1,600*.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced

by the cost or other masis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade orbusiness, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

(b) SELF-EMPLOYMENT INCOME.—The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of—

(A) for any taxable year ending prior to 1955, (i) $3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) for any taxable year ending after 1954 and before 1959, (i) $4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) for any taxable year ending after 1958 *and before 1966*, (i) $4,800, minus (ii) the amount of the wages paid to such individual during the taxable year [*: or*]*; and*

(D) *for any taxable year ending after 1965 (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; or*

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than $400.

For purposes of clause (1), the term "wages" includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or under an agreement entered into pursuant to the provisions of section 3121(1) (relating to coverage of citizens of the United States who are employees of foreign subsidiaries of domestic corporations, as would be wages under section 3121(a)) if such services constituted employment under section 3121(b). An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual.

(c) TRADE OR BUSINESS.—The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 (relating to trade or business expenses), except that such term shall not include—

(1) the performance of the functions of a public office;

(2) the performance of service by an individual as an employee, other than—

(A) service described in section 3121(b)(14)(B) performed by an individual who has attained the age of 18,

(B) service described in section 3121(b)(16),

(C) service described in section 3121(b) (11), (12), or (15) performed in the United States (as defined in section 3121(e)(2)) by a citizen of the United States, and

(D) service described in paragraph (4) of this subsection;

(3) the performance of service by an individual as an employee or employee representative as defined in section 3231;

(4) the performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order; [or]

[(5) the performance of service by an individual in the exercise of his profession as a doctor of medicine, or Christian Science practitioner or the performance of such service by a partnership.]

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner[.] *; or*

(6) the performance of service by an individual during the period for which an exemption under subsection (h) is effective with respect to him.

[The provisions of paragraph (4) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by such individual under subsection (e) is in effect. The provisions of paragraph (5) shall not apply to service performed by an individual in the exercise of his profession as a Christian Science practitioner during the period for which a certificate filed by him under subsection (e) is in effect.] *The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under subsection (e) is in effect. The provisions of paragraph (2) shall not have the effect of excluding cash tips received by an employee in the course of service which constitutes employment under chapter 21, on his own behalf and not on behalf of another person, from "net earnings from self-employment"; except that (i) this sentence shall not apply in the case of tips which constitute remuneration for employment under chapter 21, and (ii) in applying subsection (a) with respect to tips to which this sentence is applicable, only the deductions attributable to such tips shall be taken into account.*

(d) EMPLOYEE AND WAGES.—The term "employee" and the term "wages" shall have the same meaning as when used in chapter 21 (sec. 3101 and following, relating to Federal Insurance Contributions Act).

(e) MINISTERS, MEMBERS OF RELIGIOUS ORDERS, AND CHRISTIAN SCIENCE PRACTITIONERS.—

(1) WAIVER CERTIFICATE.—Any individual who is (A) a duly ordained, commissioned, or licensed minister of a church or a member of a religious order (other than a member of a religious order who has taken a vow of poverty as a member of such order)

or (B) a Christian Science practitioner may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations made under this chapter) certifying that he elects to have the insurance system established by title II of the Social Security Act [extended to service described in subsection (c)(4), or service described in subsection (c)(5) insofar as it relates to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, as the case may be, performed by him] *extended to service described in subsection (c)(4) or (c)(5) performed by him.*

(2) TIME FOR FILING CERTIFICATE.—Any individual who desires to file a certificate pursuant to paragraph (1) must file such certificate on or before whichever of the following dates is later; [(A) the due date of the return (including any extension thereof) for his second taxable year ending after 1954 for which he has net earnings from self-employment (computed, in the case of an individual referred to in paragraph (1)(A), without regard to subsection (c)(4), and, in the case of an individual referred to in paragraph (1)(B), without regard to subsection (c)(5) insofar as it relates to the performance of service by an individual in the exercise of his profession as a Christian Science practictioner) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4), or from the performance of service described in subsection (c)(5) insofar as it relates to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, as the case may be; or] *(A) the due date of the return (including any extension thereof) for his second taxable year ending after 1954 for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or (B) the due date of the return (including any extension thereof) for his second taxable year ending after 1962.*

* * * * * * *

[(5) OPTIONAL PROVISION FOR CERTAIN CERTIFICATES FILED ON OR BEFORE APRIL 15, 1962.—In any case where an individual has derived earnings, in any taxable year ending after 1954 and before 1960, from the performance of service described in subsection (c)(4), or in subsection (c)(5) (as in effect prior to the enactment of this paragraph) insofar as it related to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, and has reported such earnings as self-employment income on a return filed on or before the date of the enactment of this paragraph and on or before the due date prescribed for filing such return (including any extension thereof)—

[(A) a certificate filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c)(1)(C) of the Social Security Act) after the date of the enactment of this paragraph and on or before April 15, 1962, may be effective, at the election of the person filing such certificate, for the first taxable year ending after 1954 and before 1960 for which such a return

was filed, and for all succeeding taxable years, rather than for the period described in paragraph (3), and

[(B) a certificate filed by such individual on or before the date of the enactment of this paragraph which (but for this subparagraph) is ineffective for the first taxable year ending after 1954 and before 1959 for which such a return was filed shall be effective for such first taxable year, and for all succeeding taxable years, provided a supplemental certificate is filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c)(1)(C) of the Social Security Act) after the date of the enactment of this paragraph and on or before April 15, 1962,

but only if—

[(i) the tax under section 1401 in respect of all such individual's self-employment income (except for underpayments of tax attributable to errors made in good faith), for each such year ending before 1960 in the case of a certificate described in subparagraph (A) or for each such year ending before 1959 in the case of a certificate described in subparagraph (B), is paid on or before April 15, 1962, and

[(ii) in any case where refund has been made of any such tax which (but for this paragraph) is an overpayment, the amount refunded (including any interest paid under section 6611) is repaid on or before April 15, 1962.

The provisions of section 6401 shall not apply to any payment or repayment described in this paragraph.

[(6) CERTIFICATE FILED BY FIDUCIARIES OR SURVIVORS ON OR BEFORE APRIL 15, 1962.—In any case where an individual, whose death has occurred after September 12, 1960, and before April 16, 1962, derived earnings from the performance of services described in subsection (c)(4), or in subsection (c)(5) insofar as it relates to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, a certificate may be filed after the date of enactment of this paragraph, and on or before April 15, 1962, by a fiduciary acting for such individual's estate or by such individual's survivor within the meaning of section 205(c)(1)(C) of the Social Security Act. Such certificate shall be effective for the period prescribed in paragraph (3)(A) as if filed by the individual on the day of his death.]

(5) Optional provision for certain certificates filed on or before April 15, 1967.—Notwithstanding any other provision of this section, in any case where an individual has derived earnings in any taxable year ending after 1954 from the performance of service described in subsection (c)(4), or in subsection (c)(5) insofar as it related to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, and has reported such earnings as self-employment income on a return filed on or before the due date prescribed for filing such return (including any extension thereof)—

(A) a certificate filed by such individual on or before April 15, 1965, which (but for this subparagraph) is ineffective for the first taxable year ending after 1954 for which such a return was filed shall be effective for such first taxable

year and for all succeeding taxable years, provided a supplemental certificate is filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c)(1)(C) of the Social Security Act) after the date of enactment of this paragraph and on or before April 15, 1967, and

(B) a certificate filed after the date of enactment of this paragraph and on or before April 15, 1967, by a survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act) of such an individual who died on or before April 15, 1965, may be effective, at the election of the person filing such a certificate, for the first taxable year ending after 1954 for which such a return was filed and for all succeeding years,

but only if—

(i) The tax under section 1401 in respect to all such individual's self-employment income (except for underpayments of tax attributable to errors made in good faith), for each such year described in subparagraphs (A) and (B), is paid on or before April 15, 1967, and

The provisions of section 6401 shall not apply to any payment or repayment described in this paragraph.

(ii) in any case where refund has been made of any such tax which (but for this paragraph) is an overpayment, the amount refunded (including any interest paid under section 6611) is repaid on or before April 15, 1967.

The provisions of section 6401 shall not apply to any payment or repayment described in this paragraph.

(h) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

(1) EXEMPTION.—*Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—*

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary or his delegate may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person,

and only if the Secretary of Health, Education, and Welfare finds that—

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

(2) TIME FOR FILING APPLICATION.—*For purposes of this subsection, an application must be filed—*

(A) In the case of an individual who has self-employment income (determined without regard to this subsection and subsection (c)(6)) for any taxable year ending before December 31, 1965, on or before April 15, 1966, and

(B) In any other case, on or before the time prescribed for filing the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, for which he has self-employment income (as so determined).

(3) PERIOD FOR WHICH EXEMPTION EFFECTIVE.—*An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year—*

(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of paragraph (1), or (ii) before the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which he is a member ceases to meet the requirements of subparagraph (C) or (D).

(4) APPLICATION BY FIDUCIARIES OR SURVIVORS.—*In any case where an individual who has self-employment income dies before the expiration of the time prescribed by paragraph (2) for filing an application for exemption pursuant to this subsection, such an application may be filed with respect to such individual within such time by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act).*

* * * * * * *

[SEC. 3101. RATE OF TAX.

[In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

[(1) with respect to wages received during the calendar year 1962, the rate shall be 3⅛ percent;

[(2) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3⅝ percent;

[(3) with respect to wages received during the calendar years 1966 to 1967, both inclusive, the rate shall be 4⅛ percent; and

[(4) with respect to wages received after December 31, 1967, the rate shall be 4⅝ percent.]

SEC. 3101. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—*In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section (3121(b))—*

(1) with respect to wages received during the calendar years 1966, 1967, and 1968, the rate shall be 3.85 percent;

(2) with respect to wages received during the calendar years 1969, 1970, 1971, and 1972, the rate shall be 4.45 percent; and

(3) with respect to wages received after December 31, 1972, the rate shall be 4.9 percent.

(b) HOSPITAL INSURANCE.—*In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b)* [*but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees*]*)—*

(1) with respect to wages received during the calendar year 1966, the rate shall be 0.325 percent;

(2) with respect to wages received during the calendar years 1967, 1968, 1969 and 1970, the rate shall be 0.50 percent;

(3) with respect to wages received during the calendar years 1971 and 1972, the rate shall be 0.55 percent;

(4) with respect to wages received during the calendar years 1973, 1974, and 1975, the rate shall be 0.60 percent;

(5) with respect to wages received during the calendar years 1976, 1977, 1978, and 1979, the rate shall be 0.65 percent;

(6) with respect to wages received during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 0.75 percent; and

(7) with respect to wages received after December 31, 1986, the rate shall be 0.85 percent.

* * * * * * *

[SEC. 3111. RATE OF TAX.

[In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section

3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

[(1) with respect to wages paid during the calendar year 1962, the rate shall be 3⅛ percent;

[(2) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3⅝ percent;

[(3) with respect to wages paid during the calendar years 1966 to 1967, both inclusive, the rate shall be 4⅛ percent; and

[(4) with respect to wages paid after December 31, 1967, the rate shall be 4⅝ percent.]

[SEC. 3111. RATE OF TAX.

(a) Old-Age, Survivors, and Disability Insurance.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

(1) with respect to wages paid during the calendar years 1966, 1967, and 1968, the rate shall be 3.85 percent;

(2) with respect to wages paid during the calendar years 1969, 1970, 1971, and 1972, the rate shall be 4.45 percent; and

(3) with respect to wages paid after December 31, 1972, the rate shall be 4.9 percent.

(b) Hospital Insurance.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121 (b)[, but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees.]]—

(1) with respect to wages paid during the calendar year 1966, the rate shall be 0.325 percent;

(2) with respect to wages paid during the calendar years 1967, 1968, 1969 and 1970, the rate shall be 0.50 percent;

(3) with respect to wages paid during the calendar years 1971 and 1972, the rate shall be 0.55 percent;

(4) with respect to wages paid during the calendar years 1973, 1974, and 1975, the rate shall be 0.60 percent;

(5) with respect to wages paid during the calendar years 1976, 1977, 1978, and 1979, the rate shall be 0.65 percent;

(6) with respect to wages paid during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 0.75 percent;

(7) with respect to wages paid after December 31, 1986, the rate shall be 0.85 percent.

Subtitle C—Employment Taxes

CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

SUBCHAPTER C—GENERAL PROVISIONS

SUBCHAPTER C—GENERAL PROVISIONS

SEC. 3121. DEFINITIONS.

(a) WAGES.—For the purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term shall not include—

(1) that part of the remuneration which after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to [$4,800] *$6,600 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to* [$4,800] *$6,600 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer* [;]. *If during any calendar year an employer which is a member of an affiliated group (as defined in section 1504 (a), but determined without regard to sections 1504 (b) and (c)) employs an individual who during such calendar year, and prior to the employment of such individual by such member, was an employee of another member of such affiliated group, then, for the purpose of determining whether such member has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to*

$6,600 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such other member of such affiliated group during such calendar year, and prior to the employment of such individual by such member, shall be considered as having been paid by such member;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

(A) retirement, or

(B) sickness or accident disability, or

(C) medical or hospitalization expenses in connection with sickness or accident disability, or

(D) death;

(3) any payment made to an employee (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement;

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust,

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a), or

(C) under or to a bond purchase plan which, at the time of such payment, is a qualified bond purchase plan described in section 405(a);

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101 (or the corresponding section of prior law), or

(B) of any payment required from an employee under a State unemployment compensation law;

(7)(A) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by

the employer to the employee for such service is less than $50. As used in this subparagraph, the term "domestic service in a private home of the employer," does not include service described in subsection (g)(5);

(C) cash remuneration paid by an employer in any calendar quarter to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this subparagraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in subsection (g)(5);

(8)(A) remuneration paid in any medium other than cash for agricultural labor;

(B) cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or (ii) the employee performs agricultural labor for the employer on 20 days or more during such year for cash remuneration computed on a time basis;

(9) Any payment (other than vacation or sick pay) made to an employee after the month in which—

(A) in the case of a man, he attains the age of 65, or

(B) in the case of a woman, she attains the age of 62,

if such employee did not work for the employer in the period for which such payment is made;

(10) remuneration paid by an employer in any calendar quarter to an employee for service described in subsection (d)(3)(C) (relating to home workers), if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50; or

(11) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217.

(b) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service performed after 1936 and prior to 1955 which was employment for purposes of subchapter A of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1954 either (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen of the United States as an employee for an American employer (as defined in subsection (h)); except that, in the case of service performed after 1954, such term shall not include—

(1) service performed by foreign agricultural workers (A) under contracts entered into in accordance with title V of the

Agricultural Act of 1949, as amended (65 Stat. 119; 7 U.S.C. 1461–1468), or (B) lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3) (A) service performed by an individual in the employ of his spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter;

(4) service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft, when outside the United States and (B) (i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) service performed in the employ of any instrumentality of the United States, if such instrumentality is exempt from the tax imposed by section 3111 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;

(6) (A) service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is covered by a retirement system established by a law of the United States;

(B) service performed by an individual in the employ of an instrumentality of the United States if such an instrumentality was exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939 on December 31, 1950, and if such service is covered by a retirement system established by such instrumentality; except that the provisions of this subparagraph shall not be applicable to—

(i) service performed in the employ of a corporation which is wholly owned by the United States;

(ii) service performed in the employ of a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Home Loan Bank, or a Federal Credit Union;

(iii) service performed in the employ of a State, county, or community committee under the Commodity Stabilization Service;

(iv) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the

Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; or

(v) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast. Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;

(C) service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is performed—

(i) as the President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress;

(ii) in the legislative branch;

(iii) in a penal institution of the United States by an inmate thereof;

(iv) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government; 5 U.S.C., sec. 1052), *other than as a medical or dental intern or a medical or dental resident in training;*

(v) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

(vi) by any individual to whom the Civil Service Retirement Act does not apply because such individual is subject to another retirement system (other than the retirement system of the Tennessee Valley Authority);

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service which, under subsection (j), constitutes covered transportation service, [or]

(B) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title with respect to the taxes imposed by this chapter—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be

deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate[;], *or*

(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government; 5 U.S.C. 1052), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting or other fee basis;

(8) (A) service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(B) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) which is exempt from income tax under section 501(a), but this subparagraph shall not apply to service performed during the period for which a certificate, filed pursuant to subsection (k) (or the corresponding subsection of prior law), is in effect if such service is performed by an employee—

(i) whose signature appears on the list filed by such organization under subsection (k) (or the corresponding subsection of prior law),

(ii) who became an employee of such organization after the calendar quarter in which the certificate (other than a certificate referred to in clause (iii)) was filed, or

(iii) who, after the calendar quarter in which the certificate was filed with respect to a group described in section 3121(k)(1)(E), became a member of such group,

except that this subparagraph shall apply with respect to service performed by an employee as a member of a group described in section 3121(k)(1)(E) with respect to which no certificate is in effect;

(9) service performed by an individual as an employee or employee representative as defined in section 3231;

(10) (A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section

401(a)) or under section 521, if the remuneration for such service is less than $50;

(B) service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State, shall certify to the Secretary that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law; [and service performed as an interne in the employ of a hospital by an individual who has completed a 4 years' course in a medical school chartered or approved pursuant to State law;]

(14)(A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) service performed in the employ of an international organization;

(16) service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) service in the employ of any organization which is performed (A) in any quarter during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)); or

(19) service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purposes specified in subparagraph (F) or (J), as the case may be.

* * * * * * *

(k) EXEMPTION OF RELIGIOUS, CHARITABLE, AND CERTAIN OTHER ORGANIZATIONS.—

(1) WAIVER OF EXEMPTION BY ORGANIZATION.—

(A) An organization described in section 501(c)(3) which is exempt from income tax under section 501(a) may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations made under this chapter) certifying that it desires to have the insurance system established by title II of the Social Security Act extended to service performed by its employees. Such certificate may be filed only if it is accompanied by a list containing the signature, address, and social security account number (if any) of each employee (if any) who concurs in the filing of the certificate. Such list may be amended at any time prior to the expiration of the twenty-fourth month following the calendar quarter in which the certificate is filed by filing with the prescribed official a supplemental list or lists containing the signature, address, and social security account number (if any) of each additional employee who concurs in the filing of the certificate. The list and any supplemental list shall be filed in such form and manner as may be prescribed by regulations made under this chapter.

(B) The certificate shall be in effect (for purposes of subsection (b)(8)(B) and for purposes of section 210(a)(8)(B) of the Social Security Act) for the period beginning with whichever of the following may be designated by the organization:

(i) the first day of the calendar quarter in which the certificate is filed.

(ii) the first day of the calendar quarter succeeding such quarter, or

[(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that, in the case of a certificate filed prior to January

1, 1960, such date may not be earlier than January 1, 1956, and in the case of a certificate filed after 1959, such date may not be earlier than the first day of the fourth calendar quarter preceding the quarter in which such certificate is filed.]

(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed.

(C) In the case of service performed by an employee whose name appears on a supplemental list filed after the first month following the calendar quarter in which the certificate is filed, the certificate shall be in effect (for purposes of subsection (b)(8)(B) and for purposes of section 210(a)(8)(B) of the Social Security Act) only with respect to service performed by such individual for the period beginning with the first day of the calendar quarter in which such supplemental list is filed.

(D) The period for which a certificate filed pursuant to this subsection or the corresponding subsection of prior law is effective may be terminated by the organization, effective at the end of a calendar quarter, upon giving 2 years' advance notice in writing, but only if, at the time of the receipt of such notice, the certificate has been in effect for a period of not less than 8 years. The notice of termination may be revoked by the organization by giving, prior to the close of the calendar quarter specified in the notice of termination, a written notice of such revocation. Notice of termination or revocation thereof shall be filed in such form and manner, and with such official, as may be prescribed by regulations made under this chapter.

(E) If an organization described in subparagraph (A) employs both individuals who are in positions covered by a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof and individuals who are not in such positions, the organization shall divide its employees into two separate groups. One group shall consist of all employees who are in positions covered by such a fund or system and (i) are members of such fund or system, or (ii) are not members of such fund or system but are eligible to become members thereof; and the other group shall consist of all remaining employees. An organization which has so divided its employees into two groups may file a certificate pursuant to subparagraph (A) with respect to the employees in either group, or may file a separate certificate pursuant to such subparagraph with respect to the employees in each group.

(F) An organization which filed a certificate under this subsection after 1955 but prior to the enactment of this subparagraph may file a request at any time before 1960 to have such certificate effective, with respect to the service of individuals who concurred in the filing of such certificate (initially or through the filing of a supplemental list) prior to

enactment of this subparagraph and who concur in the filing of such new request, for the period beginning with the first day of any calendar quarter preceding the first calendar quarter for which it was effective and following the last calendar quarter of 1955. Such request shall be filed with such official and in such form and manner as may be prescribed by regulations made under this chapter. If a request is filed pursuant to this subparagraph—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for any calendar quarter resulting from the filing of such request shall be the last day of the calendar month following the calendar quarter in which the request is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(G) If a certificate filed pursuant to this paragraph is effective for one or more calendar quarters prior to the quarter in which the certificate is filed, then—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for such prior calendar quarters resulting from the filing of such certificate shall be the last day of the calendar month following the calendar quarter in which the certificate is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(H) An organization which files a certificate under subparagraph (A) before 9166 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is so amended. If an organization amends its certificate pursuant to the preceding sentence, such amendment shall be effective with respect to the service of individuals who concurred in the filing of such certificate (initially or through the filing of a supplemental list) and who concur in the filing of such amendment. An amendment to a certificate filed pursuant to this subparagraph shall be filed with such official and in such form and manner as may be prescribed by regulations made under this chapter. If an amendment is filed pursuant to this subparagraph—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for any calendar quarter resulting from the filing of such an amendment shall be the

last day of the calendar month following the calendar quarter in which the amendment is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of three years from such due date.

(2) TERMINATION OF WAIVER PERIOD BY SECRETARY OR HIS DELEGATE.—If the Secretary or his delegate finds that any organization which filed a certificate pursuant to this subsection or the corresponding subsection of prior law has failed to comply substantially with the requirements applicable with respect to the taxes imposed by this chapter or the corresponding provisions of prior law or is no longer able to comply with the requirements applicable with respect to the taxes imposed by this chapter, the Secretary or his delegate shall give such organization not less than 60 days' advance notice in writing that the period covered by such certificate will terminate at the end of the calendar quarter specified in such notice. Such notice of termination may be revoked by the Secretary or his delegate by giving, prior to the close of the calendar quarter specified in the notice of termination, written notice of such revocation to the organization. No notice of termination or of revocation thereof shall be given under this paragraph to an organization without the prior concurrence of the Secretary of Health, Education, and Welfare.

(3) NO RENEWAL OF WAIVER.—In the event the period covered by a certificate filed pursuant to this subsection or the corresponding subsection of prior law is terminated by the organization, no certificate may again be filed by such organization pursuant to this subsection.

* * * * * * *

SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the determination whether an individual has performed service which constitutes employment as defined in section 3121(b), the determination of the amount of remuneration for such service which constitutes wages as defined in section 3121(a), and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the [$4,800] *$6,600* limitation in section 3121(a)(1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121(a)(1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121(m)(1) are

applicable shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary shall be deemed to be the head of such instrumentality.

* * * * * * *

SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN GUAM [AND AMERICAN SAMOA], *AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.*

(a) GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the [$4,800] *$6,600* limitation in section 3121(a)(1).

(b) AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instumentality with respect to having such individuals in its employ, may be made by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the [$4,800] *$6,600* limitation in section 3121(a)(1).

(c) District of Columbia.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be

made by the Commissioners of the District of Columbia or by such agents as they may designate. The person making such return may, for convenience of administration, make payments of the tax imposed by section 3111 with respect to such service without regard to the $6,600 limitation in such section 3121(a)(1).

* * * * * * *

SEC. 3201. RATE OF TAX.

In addition to other taxes, there is hereby imposed on the income of every employee a tax equal to—

(1) 6¾ percent of so much of the compensation paid to such employee for services rendered by him after the month in which this provision was amended in 1959, and before January 1, 1962, and

(2) 7¼ percent of so much of the compensation paid to such employee for services rendered by him after December 31, 1961,

as is not in excess of $400 for any calendar month before the calendar month next following the month in which this provision was amended in 1963, or $450 for any calendar month after the month in which this provision was so amended: *Provided*, That the rate of tax imposed by this section shall be increased, with respect to compensation paid for services rendered after December 31, 1964, by a number of percentage points (including fractional points) equal at any given time to the number of percentage points (including fractional points) by which [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] *the rate of the tax imposed with respect to wages* [*section 3101(a)*] *section 3101(a) plus the rate imposed by section 3101(b) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3101 as amended by the Social Security Amendments of 1956).*

SEC. 3211. RATE OF TAX.

In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to—

(1) 13½ percent of so much of the compensation paid to such employee representative for services rendered by him after the month in which this provision was amended in 1959, and before January 1, 1962, and

(2) 14½ percent of so much of the compensation paid to such employee representative for services rendered by him after December 31, 1961,

as is not in excess of $400 for any calendar month before the calendar month next following the month in which this provision was amended in 1963, or $450 for any calendar month after the month in which this provision was so amended: *Provided*, That the rate of tax imposed by this section shall be increased, with respect to compensation paid for services rendered after December 31, 1964, by a number of percentage points (including fractional points) equal at any given time to twice the number of percentage points (including fractional points) by which [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] *the rate of the tax imposed with respect to wages by* [*section 3101(a)*] *section 3101(a) plus the rate imposed by section 3101(b) at such time exceeds 2¾ percent (the rate provided by paragraph 2 of section 3101 as amended by the Social Security Amendments of 1956).*

* * * * * * *

SEC. 3221. RATE OF TAX.

* * * * * * *

(b) The rate of tax imposed by subsection (a) shall be increased, with respect to compensation paid for services rendered after December 31, 1964, by a number of percentage points (including fractional points) equal at any given time to the number of percentage points (including fractional points) by which [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] *the rate of the tax imposed with respect to wages by* [*section 3111(a)*] *section 3111(a) plus the rate imposed by section 3111(b) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3111 as amended by the Social Security Amendments of 1956).*

* * * * * * *

SEC. 6051. RECEIPTS FOR EMPLOYEES.

* * * * * * *

(c) ADDITIONAL REQUIREMENTS.—The statement required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary or his delegate may by regulations prescribe. *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.*

* * * * * * *

SEC. 6205. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.

(a) ADJUSTMENT OF TAX.—

* * * * * * *

(4) District of Columbia as employer.—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125 shall be deemed a separate employer.

SEC. 6413. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.

(a) ADJUSTMENT OF TAX.—

* * * * * * *

(4) District of Columbia as employer.—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Commissioners of the District

of Columbia and each agent designated by them who makes a return pursuant to section 3125 shall be deemed a separate employer.

* * * * * * *

(c) SPECIAL REFUNDS.—

(1) IN GENERAL.—If by reason of any employee receiving wages from more than one employer during a calendar year after the calendar year 1950 and prior to the calendar year 1955, the wages received by him during such year exceed $3,600, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 1400 of the Internal Revenue Code of 1939 and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to the first $3,600 of such wages received; or if by reason of an employee receiving wages from more than one employer (A) during any calendar year after the calendar year 1954 and prior to the calendar year 1959, the wages received by him during such year exceed $4,200, or (B) during any calendar year after the calendar year 1958 *and prior to the calendar year 1966*, the wages received by him during such year exceed $4,800, *or (C) during any calendar year after the calendar year 1965, the wages received by him during such year exceed $6,600* the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101 and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to the first $4,200 of such wages received in such calendar year after 1954 and before 1959, or which exceeds the tax with respect to the first $4,800 of such wages received in such calendar year after 1958 *and before 1966, or which exceeds the tax with respect to the first $6,600 of such wages received in such calendar year after 1965.*

(2) APPLICABILITY IN CASE OF FEDERAL AND STATE EMPLOYEES, EMPLOYEES OF CERTAIN FOREIGN CORPORATIONS, AND GOVERNMENTAL EMPLOYEES IN GUAM [AND AMERICAN SAMOA], *American Samoa, and the District of Columbia.*—

(A) FEDERAL EMPLOYEES.—In the case of remuneration received from the United States or a wholly-owned instrumentality therof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall, for purposes of this subsection, be deemed a separate employer, and the term "wages" includes for purposes of this subsection the amount, not to exceed $3,600 for the calendar year 1951, 1952, 1953, or 1954, $4,200 for the calendar year 1955, 1956, 1957, or 1958, [or $4,800 for any calendar year after 1958] *$4,800 for the calendar year 1959, 1960, 1961, 1962, 1963, 1964, or 1965, or $6,600 for any calendar year after 1965*, determined by each such head or agent as constituting wages paid to an employee.

* * * * * * *

(F) Governmental employes in the District of Columbia.—In the case of remuneration received from the District of Columbia or any instrumentality wholly owned thereby during any calendar year, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125 (c) shall, for purposes of this subsection, be deemed a separate employer.

RAILROAD RETIREMENT ACT OF 1937, AS AMENDED

Definitions

Section 1. For the purposes of this Act—

* * * * * * *

(q) The terms "Social Security Act" and "Social Security Act, as amended," shall mean the Social Security Act as amended in [1961] *1965*.

* * * * * * *

Annuities and Lump Sum for Survivors

Sec. 5.

* * * * * * *

(k) PROVISIONS FOR CREDITING RAILROAD INDUSTRY SERVICE UNDER THE SOCIAL SECURITY ACT IN CERTAIN CASES.—(1) For the purpose of determining (i) insurance benefits under title II of the Social Security Act to an employee who will have completed less than ten years of service and to others deriving from him or her during his or her life and with respect to his or her death, and lump-sum death payments with respect to the death of such employee, and (ii) insurance benefits with respect to the death of an employee who will have completed ten years of service which would begin to accrue on or after January 1, 1947, and with respect to lump-sum death payments under such title payable in relation to a death of such an employee occurring on or after such date, and for the purposes of sections 203 and section 216(i)(3) of that Act, section 15 of the Railroad Retirement Act of 1935, section 210(a)(10) of the Social Security Act, and section 17 of this Act shall not operate to exclude from "employment", under title II of the Social Security Act, service which would otherwise be included in such "employment" but for such sections. For such purpose, compensation paid in a calendar year shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee will have been in service as an employee. In the application of the Social Security Act pursuant to this paragraph to service as an employee, all services as defined in section 1(c) of this Act shall be deemed to have been performed within the United States.

(2)[(A) The Board and the Secretary of Health, Education, and Welfare shall determine, no later than January 1, 1954, the amount which would place the Federal Old-Age and Survivors Insurance Trust Fund in the same position in which it would have been at the close of the fiscal year ending June 30, 1952, 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.

[(B) On January 1, 1954, for the fiscal year ending June 30, 1953, and at the close of each fiscal year beginning with the fiscal year ending June 30, 1954, the Board and the Secretary of Health, Education, and Welfare shall determine, and the Board shall certify to the Secretary of the Treasury for transfer from the Railroad Retirement Account (hereafter termed "Retirement Account") to the Federal Old-Age and Survivors Insurance Trust Fund, interest for such fiscal year at the rate specified in subparagraph (D) on the amount determined under subparagraph (A) less the sum of all offsets made under subparagraph (C) (i).]

[(C)](*A*) (i) At the close of the fiscal year ending June 30, 1953, 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 Old-Age and Survivors 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. [For the purposes of this subparagraph, the amount determined under subparagraph (A), less such offsets as have theretofore been made under this subdivision of this subparagraph, and the amount determined under subparagraph (B) for the fiscal year under consideration shall be deemed to be part of the Federal Old-Age and Survivors Insurance Trust Fund.] 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 Old-Age and Survivors 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 Old-Age and Survivors Insurance Trust Fund; if such amount is to be subtracted from the Federal Old-Age and Survivors 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 Old-Age and Survivors Insurance Trust Fund to [the Retirement Account] *the Railroad Retirement Account (hereinafter termed "Retirement Account")*. The amount so certified shall further include interest (at the rate determined in [subparagraph (D)] *subparagraph (B)* for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification. [In the event the Secretary of Health, Education, and Welfare is required under the provisions of this subdivision of this subparagraph to certify to the Secretary of the Treasury an amount to be transferred to the Retirement Account from the Federal Old-Age and Survivors Insurance Trust Fund, the Secretary of Health, Education, and Welfare, in lieu of such certification, may offset the amount determined under the first sentence of this subdivision of this subparagraph against the amount determined under subparagraph (A) as diminished by any prior offsets and the offsets shall be made to be effective as of the first day of the fiscal year following the fiscal year under consideration.]

(ii) At the close of the fiscal year ending June 30, 1958, and each fiscal year thereafter, the Board and the Secretary of Health, Educa-

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

(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; 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)] *(B)* For the purposes of [subparagraphs (B) and (C)] *subparagraph (A)*, for any fiscal year, the rate of interest to be used shall be equal to the average rate of interest, computed as of May 31 preceding the close of such fiscal year, borne by all interest-bearing obligations of the United States then forming a part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest shall be the multiple of one-eighth of 1 per centum next lower than such average rate.

[(E)] [*(C)* The Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund from the Retirement Account or to the Retirement Account from the Federal

Old-Age and Survivors Insurance Trust Fund or the Federal Disability 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 subparagraphs (B) and (C) of this subsection, 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 or the Federal Disability Insurance Trust Fund.

(3) The Board and the Secretary of Health, Education, and Welfare, shall, upon request, supply each other with certified reports of records of compensation or wages and periods of service of determinations under section 3(e) of this Act, or section 216(i) of the Social Security Act, of periods of disability within the meaning of such section 216(i) and of other records in their possession or which they may secure, pertinent to the administration of this section, section 3(e) of this Act, or title II of the Social Security Act as affected by paragraph (1). Such certified reports shall be conclusive in adjudication as to the matters covered therein (except in the case of a determination of disability under section 216(i) of the Social Security Act): *Provided*, That if the Board or the Secretary of Health, Education, and Welfare, receives evidence inconsistent with a certified report and the application involved is still in course of adjudication or otherwise open for such evidence, such recertification of such report shall be made as, in the judgment of the Board or the Secretary of Health, Education, and Welfare, whichever made the original certification, the evidence warrants. Such recertification and any subsequent recertifications shall be treated in the same manner and be subject to the same conditions as an original certification.]

(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.

(1) DEFINITIONS.—For the purpose of this section the term "employee" includes an individual who will have been an "employee", and—

* * * * * * *

(9) An employee's "average monthly remuneration" shall mean the quotient obtained by dividing (A) the sum of (i) the compensation paid to him after 1936 and before the employee's closing date, eliminating any excess over $300 for any calendar month before July 1, 1954, any excess over $350 for any calendar month after June 30,

1954, and before the calendar month next following the month in which this Act was amended in 1959, any excess over $400 for any calendar month after the month in which this Act was so amended, and before the calendar month next following the month in which this Act was amended in 1963 and any excess over $450 for any calendar month after the month in which this Act was so amended, and (ii) if such compensation for any calendar year before 1955 is less than $3,600 or for any calendar year after 1954 and before 1959 is less than $4,200, or for any calendar year [after 1958 is less than $4,800] *after 1958 and before 1966 is less than $4,800, or for any calendar year after 1965 is less than $6,600*, and the average monthly remuneration computed on compensation alone is less than $450 and the employee has earned in such calendar year "wages" as defined in paragraph (6) hereof, such wages, in an amount not to exceed the difference between the compensation for such year and $3,600 for years before 1955, $4,200 for years after 1954 and before 1959, [and $4,800 for years after 1958] *$4,800 for years after 1958 and before 1966, and $6,600 for years after 1965*, by (B) three times the number of quarters elapsing after 1936 and before the employee's closing date: *Provided*, That for the period prior to and including the calendar year in which he will have attained the age of twenty-two there shall be included in the divisor not more than three times the number of quarters of coverage in such period: *Provided, further*, That there shall be excluded from the divisor any calendar quarter which is not a quarter of coverage and during any part of which a retirement annuity will have been payable to him. An employee's "closing date" shall mean (A) the first day of the first calendar year in which such employee both had attained age 65 and was completely insured; or (B) the first day of the calendar year in which such employee died; or (C) the first day of the calendar year following the year in which such employee died, whichever would produce the highest "average monthly remuneration" as defined in the preceding sentence. If the amount of the "average monthly remuneration" as computed under this paragraph is not a multiple of $1, it shall be rounded to the next lower multiple of $1.

With respect to an employee who will have been awarded a retirement annuity, the term "compensation" shall, for the purposes of this paragraph, mean the compensation on which such annuity will have been based;

* * * * * * *

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 compensation 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 sur-*

vivors. 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.]

Sec. 21. (*a*) *For the purposes of this section, and subject to the conditions hereinafter provided, 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 extend care services, post-hospital home health services, and outpatient hospital diagnostic services (all hereinafter referred to as 'services') within the meaning of 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. The rights of individuals described in subsection* (*b*) *of this section to have payment made on their behalf for the services referred to in the next preceding sentence 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 section shall be administered by the Board as if the provisions of such section and such part A 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 section 1862*(*a*)(*4*), *1863, 1867, 1868, 1874*(*b*), *and 1875 of such title XVIII were not included in such title. 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.*

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

(*A*) *has attained age 65, and*

(*B*)(*i*) *is entitled to an annuity, or* (*ii*) *would be entitled to 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* (*iii*) *had been awarded a pension under section 6, or* (*iv*) *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 survivor,*

shall be entitled to have payment made for the services referred to in subsection (*a*), *and in accordance with the provisions of such subsection. The payments for services herein provided for 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, including such services provided in Canada to individuals to whom this subsection 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 this section, an individual shall be entitled to have payment made for the services referred to in subsection (a) provided during the month in which he died if he would be entitled to have payment for services provided during such month had he died in the next month.

(c) No individual shall be entitled to have payment made for the same services, which are provided for in this section, under both (i) this section and (ii) section 226, and part A of title XVIII, of the Social Security Act, and no individual shall be entitled to have payment made under both (i) this section and (ii) section 226, and part A of title XVIII, of the Social Security Act for more than would be payable if he were qualified only under the provisions described in clause (i) or only under the provisions described in clause (ii). In any case in which an individual would, but for the preceding sentence, be entitled to have payment made under both the provisions described in clause (i) and the provisions described in clause (ii) in such preceding sentence, payment for such services to which such individual would be entitled shall be made in accordance with the procedures established pursuant to the next succeeding sentence, upon certification by the Board or by the Secretary of Health, Education, and Welfare. It shall be the duty of the Board and such Secretary with respect to such cases jointly to establish procedures designed to minimize duplications of requests for payment for such services, and of determinations, and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of this section and section 226, and part A of title XVIII, of the Social Security Act; and subject to the provisions of this subsection to assure that the rights of individuals under this section or section 226, and part A of title XVIII, or the Social Security Act shall not be impaired or diminished by reason of the administration of this section and section 226, and part A of title XVIII, of the Social Security Act. The procedures so established may be included in regulations issued by the Board and by the Secretary of Health, Education, and Welfare to implement this section and such section 226, and part A of title XVIII, respectively.

(d) Any agreement entered into by the Secretary of Health, Education, and Welfare pursuant to part A or part C of title XVIII of the Social Security Act shall be entered into on behalf of both such Secretary and the Board. The preceding sentence shall not be construed to limit the authority of the Board to enter on its own behalf into any such agreement relating to services provided in Canada or in any facility devoted primarily to railroad employees.

(e) A request for payment for services filed under this section shall be deemed to be a request for payment for services filed as of the same time under section 226, and part A of title XVIII, of the Social Security Act, and a request for payment for services filed under such section 226 and such part shall be deemed to be a request for payment for services filed as of the same time under this section.

(f) The Board and the Secretary of Health, Education, and Welfare shall furnish each other with such information, records, and documents 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.

(g) Any payment to any provider of services or other person (covered by this section or part B of title XVIII of the Social Security Act) with respect to items or services furnished any individual who meets the requirements of subsection (b) of this section shall be governed, to the extent applicable, and as if references to the Secretary were references to the Board, by the provisions of section 1870 of the Social Security Act and treated for the purposes of section 9 of this Act, as if it were a payment of an annuity or pension, except that any recovery of overpayment under part B of title XVIII of the Social Security Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

(h) 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.

(i) There are authorized to be appropriated to the Railroad Retirement Account from time to time such sums as the Board finds sufficient to cover—

(1) the costs of payments made from such account under this section,

(2) the additional administrative expenses resulting from such payments, and

(3) any loss of interest to such account resulting from such payments,

in cases where such payments are not includible in determinations under section 5(k)(2)(A)(iii) of this Act, provided such payments could have been made as a result of section 103 of the Health Insurance for the Aged Act but for eligibility under subsection (b) of this section.

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