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COMMITTEE ON FINANCE
UNITED STATES SENATE

HARRY FLOOD BYRD, *Chairman*

TEXT OF AND JUSTIFICATIONS FOR AMENDMENTS TO H.R. 6675 RECOMMENDED BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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TEXT OF AND JUSTIFICATIONS FOR AMENDMENTS TO H.R. 6675 RECOMMENDED BY THE DEPARTMENT OF HEALTH EDUCATION, AND WELFARE

I. BASIC HOSPITAL INSURANCE AND VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE PLANS

A. Combine Inpatient Hospital Services Under Part A and Inpatient Psychiatric Hospital Services Under Part B for Purposes of the Limitation of Inpatient Hospital Services to 60 Days During a Spell of Illness

TEXT

On page 11, line 6, insert "or inpatient psychiatric hospital services" after "such services".

On page 12, line 18, before the comma at the end of the line, insert "of this section and subsection (a)(1) of section 1834".

On page 36, line 19, insert "or inpatient hospital services" after "such services".

On page 37, line 14, insert "of this section and subsections (b) and (c) of section 1812" before the comma.

JUSTIFICATION

As presently drafted, the bill is not clear that days of inpatient hospital services and days of inpatient psychiatric hospital services should be added for purposes of the limitation of 60 days of coverage during a spell of illness. The proposed changes would make this clear and would prevent any incentives to transfer from a general hospital to a psychiatric hospital, or vice versa, in order to get coverage of more than 60 days of care in a spell of illness.

B. Provide for Coordination of Coverage of Diagnostic Services Under Part A and Part B

TEXT

On page 13, strike out lines 5 through 11 and insert in lieu thereof "deductible."

On page 19, line 20, before the period, insert "; except that, in the case of outpatient hospital diagnostic services, such amount shall be equal to 80 percent of such cost".

On page 35, line 12, before the period, insert ", and except that the amount of any deductible imposed under section 1813(a)(2) with respect to outpatient hospital diagnostic services furnished in any

year shall be regarded as an incurred expense under this part for such year".

On page 93, line 16, before the period, insert "or, in the case of outpatient hospital diagnostic services, for which payment may be made under part A".

JUSTIFICATION

Under the House-passed bill, for persons insured under both the basic and supplementary plan, there would be differences in the extent to which the patient's expenses for outpatient services are reimbursed depending on whether the services are rendered in an outpatient section of a hospital or in a physician's office. The $50 deductible and coinsurance provision under the supplementary plan in some cases create a financial incentive for a beneficiary to obtain diagnostic services in the outpatient department of a hospital, in which event the services would be subject only to a $20 deductible; in other cases the incentive would be in the opposite direction.

The changes proposed would minimize differences in reimbursement under part A and part B by providing for payment of 80 percent, rather than 100 percent, of the cost (above the deductible) of outpatient hospital diagnostic services covered under part A, and by counting the outpatient deductible under part A as an incurred expense under part B. The changes would also minimize the problems that beneficiaries would otherwise face in deciding whether to have diagnostic services performed in a hospital or a physician's office.

II. BASIC HOSPITAL INSURANCE PLAN

A. Inclusion of Medical Specialists

TEXT

On page 64, line 12, strike out "intern" and insert in lieu thereof "intern (other than services provided in the field of pathology, radiology, physiatry, or anesthesiology)" (amendment 156, Senator Douglas and others).

JUSTIFICATION

Secretary Celebrezze stated in the hearings:

ANCILLARY HOSPITAL SERVICES

Mr. Chairman, it would be a mistake, in my opinion, to exclude from coverage under the basic hospital insurance plan, as H.R. 6675 does, the services furnished hospital patients under arrangements with the hospital, by medical specialists in the fields of radiology, anesthesiology, pathology, and physical medicine. These services should be covered under the basic hospital insurance plan subject to the conditions set forth in the Senate-passed bill of last year and in the bill introduced in this Congress by the distinguished senior Senator from New Mexico.

Our primary concern is that medical services furnished to hospital patients in these fields be covered under this bill in a way that is in

accord with the practices that hospitals and the health professions have developed over the years.

Thus, we believe that the services in question should be covered as part of the hospital benefit if the specialist-hospital arrangement calls for the bill to be paid through the hospital.

Conversely, we believe that, where the arrangements are that the specialist is not paid by or through the hospital, reimbursement for the specialist's services should be made under the supplementary plan.

The specialists in these fields work in hospitals under various kinds of arrangements. Some work as hospital employees and are paid a salary, while others receive agreed upon percentages of the hospital's receipts for the services they furnish. Some of these specialists bill their patients directly.

The approach we suggest would follow whatever practices now exist or whatever practices may be arranged in the future in this field. On the other hand, the provisions in H.R. 6675, which exclude the hospital-related services of these specialists from coverage under the basic hospital insurance provisions, would require substantial changes in the way these services are now paid for.

The billing for the nonphysician components of the affected hospital department would have to be entirely separate from the billing for the physician services in the department. There are very few hospitals in the country that operate today on such a basis in the fields of pathology and radiology. Nor is there a health insurance plan, so far as we are aware, which requires the separation of the services of these specialists from the services provided by the hospital generally irrespective of the arrangements agreed upon by the hospital and the specialists.

B. Inclusion of Combinations of Drugs or Biologicals in the Definition Thereof

TEXT

On page 83, line 15, insert "(1)" after "only" and "(or approved for inclusion)" after "included".

On page 83, line 19, strike out "as are approved" and insert in lieu thereof "(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,".

On page 83, line 22, before the period, insert ", for use in such hospital".

JUSTIFICATION

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, may not. The proposed changes would permit such drugs to be covered under part A if provided as a part of covered inpatient hospital services or extended care facility services.

III. VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE PLAN

A. Change of Designation of Supplementary Program

TEXT

Change all references in the bill from "supplementary health insurance" to "supplementary medical insurance".

JUSTIFICATION

Changing "supplementary health insurance" to "supplementary medical insurance" wherever it appears in the bill would make more clear the distinction between the compulsory hospital insurance program and the voluntary health insurance program and promote better understanding among beneficiaries about the coverages under each program.

B. Improvement of Provisions on Administration of Benefits Under Supplementary Health Insurance Program

TEXT

On page 53, strike out lines 14 through 19 and insert in lieu thereof the following:

> "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 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:

JUSTIFICATION

Under the present 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 bill specifies that, except as otherwise provided under the bill, the Secretary may perform any of his functions directly or by contract.

The proposed changes 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. As under present language, it would still be required that, to the extent possible, doctors would be paid through carriers. Under the proposed 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 proposed changes would permit the Secretary to use carriers under section 1842 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.

C. Combine Physicians' Services and Medical and Other Health Services and Include Services Incidental to Physicians' Services

TEXT

On page 33, strike out lines 18 through 21 and insert in lieu thereof "for medical and other health services, except those described in paragraph (2) (C); and".

On page 34, line 5, insert", other than physicians' services," after "health services".

On page 82, strike out line 14 and insert in lieu thereof

care services, or home health services):

(1) physicians' services;

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

On page 82, lines 15, 18, 20, and 22, and page 83, lines 1, 5, and 8, redesignate paragraphs (1), (2), (3), (4), (5), (6), and (7) as paragraphs (3), (4), (5), (6), (7), (8), and (9), respectively.

JUSTIFICATION

The charges by a physician for services furnished in the home or office usually take into account items, supplies, equipment, and services of aids, etc., which are customarily considered incident to the physician's personal services. The proposed change would make clear that payment could be made for such items, supplies, etc., regardless of whether the physician performs his personal services in a hospital, a clinic, or in his office, and regardless of whether the bills for the

services and the incidental items, supplies, etc., are rendered by the physician, by a hospital, etc., or by both.

D. Option To Receive Payment on Basis of Cost Instead of Charges for Prepayment Organizations

TEXT

On page 34, line 22, strike out "and" and insert in lieu thereof:

> except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such service 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

JUSTIFICATION

The present bill provides for payment of the reasonable charges for physicians' services. However, under prepaid group practice plans, covered medical services are provided directly by the physicians associated with the plan to a member without charge other than the membership fee that the patient has paid to the plan. As an alternative to paying such a plan 80 percent of reasonable charges for covered services, the proposed change would permit payment of 80 percent of the reasonable cost of providing the covered services.

E. Provide Standards for Independent Laboratories Performing Diagnostic Tests Under the Supplementary Health Insurance Program

TEXT

On page 83, between lines 11 and 12, insert the following new sentence:

> No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (1) unless such laboratory—
>
> (A) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (i) is licensed pursuant to such law, or (ii) 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
>
> (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.

On page 90, line 12, before the period, insert ", or whether a laboratory meets the requirements of subparagraphs (A) and (B) of section 1861 (s)".

JUSTIFICATION

Public health authorities have expressed concern about the effects of payment under the supplementary insurance program for diagnostic tests which are not performed in a hospital or in the attending physician's office. In recent years there has been a rapid growth of so-called free standing laboratories specializing in volume testing and mail order operations. Investigation by State health authorities has produced evidence of unsanitary conditions, errors in tests, faulty records, and subcontracting of work on specimens. Some States have established requirements that these laboratories must meet in order to operate. The proposed change would support State efforts in this direction and would assure that the laboratories meet the same standards essential to the health and safety of beneficiaries as hospital laboratories.

F. PROVIDE FOR THE DEDUCTION FROM CSC ANNUITIES OF PREMIUMS UNDER THE SUPPLEMENTARY HEALTH INSURANCE BENEFITS PROGRAM

TEXT

On page 48, between lines 15 and 16, insert the following new subsection:

(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 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 Health Insurance Benefits 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.

On page 48, lines 16 and 23, strike out "(c)" and insert in lieu thereof "(f)".

On page 48, line 22, strike out "(f)" and insert in lieu thereof "(g)".

On page 49, line 1, strike out "(g)" and insert "(h)".

On page 53, between lines 12 and 13, insert the following new subsection:

> (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(c). 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.

JUSTIFICATION

The amendment would facilitate the collection of premiums under the supplementary health insurance benefits plan. There are several hundred thousand civil service annuitants (and their spouses) who are 65 years or older and who are not insured under the social security or railroad retirement systems. As the bill is now drafted, individual premium collection machinery would have to apply to such individuals. It would be much simpler and more economical if the premiums were deducted automatically from the annuities of civil service annuitants and their spouses each month just as social security and railroad retirement beneficiaries would have the premiums deducted from their monthly cash benefits.

The effect of the recommended change is that if a civil service annuitant enrolled under the supplementary health insurance benefits plan his premium amount would be withheld from the monthly installment of his annuity. If the spouse of a civil service annuitant enrolled under the supplementary plan, the premium would be withheld from her husband's annuity if he agreed to it. There is provision for reimbursing the Civil Service Commission for the amounts it would cost them to make the necessary withholdings.

G. "Physician" Limited to Doctors of Medicine or Osteopathy

TEXT

On page 82, lines 5 and 6, strike out "an individual" and insert in lieu thereof "a doctor of medicine or osteopathy".

JUSTIFICATION

The change is needed to make it clear that the term "physician" includes doctors of medicine and doctors of osteopathy but not other practitioners who, under the laws of some States, may be licensed to practice medicine and surgery.

IV. OASDI

A. Provision To Authorize the Federal Courts To Prescribe the Fees That Attorneys May Charge Their Clients for Representing Them in Court Cases Arising Under the Social Security Program

TEXT

On page 266, between lines 22 and 23, insert the following new section:

DETERMINATION OF ATTORNEYS' FEES IN COURT PROCEEDINGS UNDER TITLE II

SEC. . The heading of section 206 of the Social Security Act is amended to read "REPRESENTATION OF CLAIMANTS". Such section is further amended by inserting "(a)" after "SEC. 206." and by adding at the end of such section the following new subsection:

"(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 205(i), 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."

JUSTIFICATION

This amendment is designed to alleviate two problems that have arisen with respect to representation of claimants by attorneys. The first relates to the need to encourage effective legal representation of claimants. Under the provisions of section 205(i) of the Social Security Act, accrued amounts of benefits that are due to a claimant as a result of a court decision are to be paid directly to him. Under section 207, assignment of benefits is prohibited. Attorneys have complained that such awards are sometimes made to the claimant without the attorney's knowledge and that some claimants on occasion have not notified the attorney of the receipt of the money, nor have they paid his fee.

Another problem that has arisen is that attorneys have on occasion charged what appeared to be inordinately large fees for representing

claimants in Federal district court actions arising under the social security program. Usually, these inordinately 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, may be payable if the claimant wins his case.

The amendment 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. Any violation would be made subject to the same penalties as are provided in section 206 of the law for charging more than the maximum fees prescribed in regulations (20 CFR 404.975) for services rendered in proceedings before the Secretary. In addition, as a specific exception to section 205(i), the Secretary would be permitted to certify the amount of the court-approved fee to the attorney out of the amount of accrued benefits. As a result, claimants would be insured more effective legal representation and also would be protected from being charged exorbitant fees.

B. Provision To Simplify Payment of Wife's, Widow's, or Mother's Benefits to Divorced Women

TEXT

On page 205, lines 6 and 7, and page 208, line 16, strike out "has not remarried" and insert in lieu thereof "is not married".

On page 207, strike out lines 5 through 20, and on line 21, strike out "(4)" and insert in in lieu thereof "(3)".

On page 210, strike out lines 14 through 25.

On page 211, strike out lines 1 through 14, and insert in lieu thereof:

> (2) Paragraph (3) of section 202(e) of such Act is repealed.
>
> (3) Section 202(e) of such Act is amended by redesignating paragraph (4) as paragraph (3) and such paragraph is further amended by striking out "widow" and inserting in lieu thereof "widow or surviving divorced wife" and by striking out "widow's" and inserting in lieu thereof "widow's or surviving divorced wife's".

On page 212, line 23, strike out "(3)" and insert in lieu thereof "(4)".

On page 212, between lines 22 and 23, insert the following:

> (3) Subparagraph (A) of section 202(g)(1) of such Act is amended by striking out "has not remarried" and inserting in lieu thereof "is not married".

On page 213, strike out lines 21 through 25, and page 214, strike out lines 1 through 14.

On page 215, after line 25, insert:

> (12) Paragraph (3) of section 202(g) of such Act is repealed.
>
> (13) Section 202(g) of such Act is amended by redesignating paragraph (4) as paragraph (3).

JUSTIFICATION

Section 308 of H.R. 6675 (as passed by the House of Representatives) contains several complex provisions relating to special treatment in cases where a divorced woman remarries. Not only are the provisions complex, but if they are enacted in their present form an unintended anomalous situation would arise. This situation is that of a woman who was married to a worker long enough to eventually qualify for widow's benefits (either as his widow, if the marriage ended in his death, or as his surviving divorced wife, if he died after the marriage ended in divorce) and yet could not, because of a subsequent remarriage that ended in death after more than 1 year or divorce after more than 20 years, become entitled at age 60 to widow's benefits based on the first husband's earnings record.

A considerable simplification of the provision, as well as a solution to this problem situation, could be achieved by a change that would assure that where a widow (or surviving divorced wife) is not married at age 60 or over she will have whatever rights to benefits she has ever had, regardless of intervening marriages which have ended in death or divorce. Similar changes would also be made in the provisions for paying wife's benefits to divorced wives and for paying mother's insurance benefit to young widows and "surviving divorced mothers" (termed "former wives divorced" under present law).

C. PERMIT THE VALIDATION OF COVERAGE OF CERTAIN MINISTERS WHO REPORTED THEIR EARNINGS FOR SOCIAL SECURITY PURPOSES FOR YEARS AFTER 1954 EVEN THOUGH THEY HAD NOT FILED WAIVER CERTIFICATES EFFECTIVE FOR THOSE YEARS

TEXT

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications, the new section 329, relating to overpayments and underpayments, and the new section 330, relating to payments to two or more individuals of the same family), insert the following new section:

VALIDATING CERTIFICATES FILED BY MINISTERS

SEC. 331. (a) Section 1402(e) of the Internal Revenue Code of 1954 (relating to certificates to waive tax on self-employment income in the case of ministers, members of religious orders, and Christian Science practitioners) is amended by striking out paragraphs (5) and (6) and inserting in lieu thereof the following:

"(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

claimants in Federal district court actions arising under the social security program. Usually, these inordinately 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, may be payable if the claimant wins his case.

The amendment 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. Any violation would be made subject to the same penalties as are provided in section 206 of the law for charging more than the maximum fees prescribed in regulations (20 CFR 404.975) for services rendered in proceedings before the Secretary. In addition, as a specific exception to section 205(i), the Secretary would be permitted to certify the amount of the court-approved fee to the attorney out of the amount of accrued benefits. As a result, claimants would be insured more effective legal representation and also would be protected from being charged exorbitant fees.

B. Provision To Simplify Payment of Wife's, Widow's, or Mother's Benefits to Divorced Women

TEXT

On page 205, lines 6 and 7, and page 208, line 16, strike out "has not remarried" and insert in lieu thereof "is not married".

On page 207, strike out lines 5 through 20, and on line 21, strike out "(4)" and insert in in lieu thereof "(3)".

On page 210, strike out lines 14 through 25.

On page 211, strike out lines 1 through 14, and insert in lieu thereof:

(2) Paragraph (3) of section 202(e) of such Act is repealed.

(3) Section 202(e) of such Act is amended by redesignating paragraph (4) as paragraph (3) and such paragraph is further amended by striking out "widow" and inserting in lieu thereof "widow or surviving divorced wife" and by striking out "widow's" and inserting in lieu thereof "widow's or surviving divorced wife's".

On page 212, line 23, strike out "(3)" and insert in lieu thereof "(4)".

On page 212, between lines 22 and 23 insert the following:

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On page 213, strike out lines 21 through 25, and page 214, strike out lines 1 through 14.

On page 215, after line 25, insert:

(12) Paragraph (3) of section 202(g) of such Act is repealed.

(13) Section 202(g) of such Act is amended by redesignating paragraph (4) as paragraph (3).

JUSTIFICATION

Section 308 of H.R. 6675 (as passed by the House of Representatives) contains several complex provisions relating to special treatment in cases where a divorced woman remarries. Not only are the provisions complex, but if they are enacted in their present form an unintended anomalous situation would arise. This situation is that of a woman who was married to a worker long enough to eventually qualify for widow's benefits (either as his widow, if the marriage ended in his death, or as his surviving divorced wife, if he died after the marriage ended in divorce) and yet could not, because of a subsequent remarriage that ended in death after more than 1 year or divorce after more than 20 years, become entitled at age 60 to widow's benefits based on the first husband's earnings record.

A considerable simplification of the provision, as well as a solution to this problem situation, could be achieved by a change that would assure that where a widow (or surviving divorced wife) is not married at age 60 or over she will have whatever rights to benefits she has ever had, regardless of intervening marriages which have ended in death or divorce. Similar changes would also be made in the provisions for paying wife's benefits to divorced wives and for paying mother's insurance benefit to young widows and "surviving divorced mothers" (termed "former wives divorced" under present law).

C. PERMIT THE VALIDATION OF COVERAGE OF CERTAIN MINISTERS WHO REPORTED THEIR EARNINGS FOR SOCIAL SECURITY PURPOSES FOR YEARS AFTER 1954 EVEN THOUGH THEY HAD NOT FILED WAIVER CERTIFICATES EFFECTIVE FOR THOSE YEARS

TEXT

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications, the new section 329, relating to overpayments and underpayments, and the new section 330, relating to payments to two or more individuals of the same family), insert the following new section:

VALIDATING CERTIFICATES FILED BY MINISTERS

SEC. 331. (a) Section 1402(e) of the Internal Revenue Code of 1954 (relating to certificates to waive tax on self-employment income in the case of ministers, members of religious orders, and Christian Science practitioners) is amended by striking out paragraphs (5) and (6) and inserting in lieu thereof the following:

"(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

"(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."

(b) In the case of a certificate or supplemental certificate filed pursuant to section 1402(e)(5) of the Internal Revenue Code—

(1) for purposes of computing interest, the due date for the payment of the tax under section 1401 of such Code which is due for any taxable year solely by reason of the filing of a certificate which is effective under such section 1402(e)(5) shall be April 15, 1967;

(2) for purposes of section 6501 of such Code, the statutory period for the assessment of any tax for any taxable year for which tax is due solely by reason of the filing of such certificate shall not expire before April 16, 1970; and

(3) for purposes of section 6651 of such Code (relating to addition to tax for failure to file tax return), the amount of tax required to be shown on the return shall not include tax under section 1401 of such Code which is

due for any taxable year solely by reason of the filing of a certificate which is effective under section 1402(e)(5).

(c) Notwithstanding any provision of section 205(c)(5)(F) of the Social Security Act, the Secretary of Health, Education, and Welfare may conform, before April 16, 1970, his records to tax returns or statements of earnings which constitute self-employment income solely by reason of the filing of a certificate which is effective under section 1402(e)(5) of such Code.

(d) The amendments made by this section shall be applicable (except as otherwise specifically provided therein) only to certificates with respect to which supplemental certificates are filed pursuant to section 1402(e)(5)(A) of such Code after the date of the enactment of this Act, and to certificates filed pursuant to section 1402(e)(5)(B) after such date; except that no monthly benefits under title II of the Social Security Act for the month in which this Act is enacted or any prior month shall be payable or increased by reason of such amendments, and no lump-sum death payment under such title shall be payable or increased by reason of such amendments in the case of any individual who died prior to the date of the enactment of this Act. The provisions of section 1402(e)(5) and (6) of the Internal Revenue Code of 1954 which were in effect before the date of enactment of this Act shall be applicable with respect to any certificate filed pursuant thereto before such date if a supplemental certificate is not filed with respect to such certificate as provided in this section.

JUSTIFICATION

Under present law, ministers who have been in practice for at least 2 years had until April 15, 1965, to file certificates electing social security coverage. In some cases ministers have reported their earnings for social security purposes and paid the social security tax for several years without ever filing the required waiver certificate. The absence of a waiver certificate is not discovered until the death or retirement of a minister, and benefits are either reduced or denied altogether as a result of the failure of the minister to file the certificate.

The statute of limitations does permit some ministers who have been reporting their earnings for social security purposes for several years without filing the required waiver certificate to retain some social security credits. Generally, self-employment income credited to an individual's earnings record for a taxable year may be removed only within 3 years 3 months and 15 days following the end of that taxable year. Thus, a minister who has been reporting his earnings erroneously since 1955, for example, and whose situation came to our attention after April 15, 1965, will still be able to retain his social security credits for the years 1955 through 1961. However, the amount of benefits payable would most likely be considerably less than if credit for years after 1961 were permitted to be used in the computation of benefits. (Such a situation exists in the case of the late Rev. Donald Aksel Olsen whose widow and minor children are receiving greatly reduced social security benefits as a result of Reverend Olsen's failure to file a waiver certificate. A private bill for the relief

of his widow and minor children passed the House of Representatives in 1964.)

To assure prompt discovery of the absence of a waiver, where ministers' tax returns are filed in the future, the Social Security Administration has recently instituted a system whereby self-employment tax returns filed by ministers are checked against our files to see if each minister who reports his earnings for social security purposes has filed a valid waiver. If the minister has not filed a waiver, and is eligible to do so, we will contact him and secure the waiver.

Under the proposed amendment, a minister who filed a waiver certificate by April 15, 1965 (the expiration date of the present filing deadline), which was not effective for the first year after 1954 for which he reported his earnings for social security purposes would be permitted to file by April 15, 1967, a supplemental waiver certificate making his original waiver certificate effective with the first year after 1954 for which he filed social security returns.

In addition, the survivors of a minister who died on or before April 15, 1965, and who had filed social security returns without having filed a waiver, would be permitted to file a waiver on the minister's behalf by April 15, 1967, which would be effective with the first year after 1954 for which the minister filed social security returns.

The proposal provides that all social security taxes due for each year for which a supplemental waiver filed by a minister, or a waiver filed by a survivor must be paid, or if previously refunded, repaid, by April 15, 1967, without interest. Benefits would be payable or increased beginning with the month after enactment.

The Bureau of the Budget has expressed interest in validating legislation of this type. There has also been White House interest expressed on behalf of the widow of a minister who filed social security returns without ever filing a waiver certificate.

The cost of this proposal would be negligible.

NOTE.—The proposed amendment is very similar to the ministers' validating provisions in the 1960 amendments.

D. PROVIDE ALTERNATE RULES FOR DETERMINING WHICH BENEFIT IS PAYABLE TO AN INDIVIDUAL SIMULTANEOUSLY ENTITLED TO A DISABILITY INSURANCE BENEFIT AND AN OLD-AGE INSURANCE BENEFIT

TEXT

On page 184, lines 4 and 5, strike out "such disability insurance benefit for such month" and insert in lieu thereof—

> 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

JUSTIFICATION

The change on page 184 is needed because in some disability freeze cases—especially in the case of blind people who become entitled to the disability freeze but continue to work and earn substantial amounts—the reduced old-age insurance benefit is larger than the disability insurance benefit, and in such a case the disability beneficiary can become entitled, under present law, to the old-age insurance

benefit before he reaches age 65. The difference in the benefit amount in such cases occurs because (1) earnings in a period of disability are *excluded* in the disability insurance benefit computation and (2) earnings in the period of disability can be *included* in the old-age insurance benefit computation. Blind people have been advised to apply for the disability freeze and have been assured that this would guarantee that their benefit would be the largest they could qualify for under any provision of the law.

The portion of this change which would permit a beneficiary to elect the smaller benefit is needed in order to continue a present practice. Some people getting disability insurance benefits apply for the lower old-age insurance benefit after they reach age 62, if they have substantial earnings, because they would rather have a smaller benefit and have the retirement test apply than be annoyed by periodic investigations of their disability status and the uncertainty of knowing what benefits they can count on getting. There seems to be no good reason why a worker who is eligible for both should not be allowed to choose between a disability insurance benefit and an old-age insurance benefit.

E. Extend the Life of Applications for Social Security Benefits and Determinations of Disability to the Date of the Final Decision Thereon by the Secretary

TEXT

On page 266, between lines 22 and 23, insert the following new section:

APPLICATIONS FOR BENEFITS

SEC. 328. (a) Section 202(j)(2) of the Social Security Act is amended to read as follows:

"(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."

(b) Section 216(i)(2) of such Act (as amended by subsection (b)(1) of section 303) is amended by striking out subparagraph (E) and inserting in lieu thereof the following:

"(E) 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 in such first month."

(c) The first sentence of section 223(b) of such Act is amended to read as follows:

"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."

(d) The amendments made by this section shall apply with respect to (1) applications filed on or after the date of enactment of this Act (2) applications as to which the Secretary has not made a final decision before the date of enactment of this Act, and (3) if a civil action with respect to final decision by the Secretary has been commenced under section 205(g) of the Social Security Act before the date of enactment of this Act, applications as to which there has been no final judicial decision before the date of enactment of this Act.

JUSTIFICATION

Under present law, the prospective life of an application for monthly social security 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 eligibility 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, 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. In such a case, 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.

Such cases appear inequitable; yet, without the proposed change, the only complete remedy is to take repeated applications to prevent loss of benefits in cases which are in process for a considerable period to obtain needed evidence or because of reconsideration and appeals.

There would be no cost to the program as a result of this change.

F. Overpayments and Underpayments

TEXT

On page 102, strike out everything beginning with line 9 and down to and including line 9 on page 103 and insert in lieu thereof the following:

"(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(c) or 1835(c) 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."

On page 103, lines 10 and 16, after "adjustment" insert "or recovery".

On page 103, strike out everything beginning with line 18 to and including line 24 and insert in lieu thereof the following:

"(c) There shall be no adjustment as provided in subsection (b) of payments (including payments under section 1814(c) and 1835(c)) 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."

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications), insert the following new section;

OVERPAYMENTS AND UNDERPAYMENTS

SEC. 329. (a) Section 204(a) of the Social Security Act is amended to read as follows:

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) Section 204(b) of such Act is amended to read as follows:

"(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."

JUSTIFICATION

Overpayments

Under section 1870 of the Social Security Act, as added by H.R. 6675, the Secretary is authorized to recover a health benefit overpayment made to or on behalf of a person (who will be referred to, for convenience, as the "overpaid person") by withholding the cash social security or railroad retirement benefits payable to him or, if he should die, by withholding such benefits payable to others getting benefits on the same earnings record. This provision parallels the provision in present law relating to the recovery of cash benefit overpayments. Neither the provision in H.R. 6675 nor the provision in present law specifically authorizes recovery through withholding benefits payable to another person getting benefits on the same earnings record where the overpaid person is still alive.

An administrative procedure has been developed, and has been used for about 20 years, under which an incorrect payment made to one beneficiary who becomes ineligible for benefits is recovered from benefits subsequently payable to another beneficiary in those cases where the latter was living with the overpaid person at the time the overpayment was made (and presumably, therefore, shared in the overpayment) and is living with the overpaid person at the time the action is taken to recover the overpayment. Since there is no specific legal authority for present practice, it cannot be followed if the beneficiary whose benefits are being withheld objects. If the person objects after his benefits have been withheld, any benefits withheld must be repaid.

The General Accounting Office, in a report to the Congress dated July 25, 1961, recommended that the Secretary of Health, Education, and Welfare seek legislative authority to recover overpayments to a living person by withholding benefits of other people getting benefits on the same earnings record. Under the proposal, the Secretary would have authority, in any case where there had been an overpayment of either health benefits or cash benefits, to recover

the overpayment by withholding the cash social security benefits (and, in the case of an overpayment of health benefits, cash railroad retirement 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.

Under section 1870 of the Social Security Act, as added by H.R. 6675, and also under present law, a beneficiary who is liable for repayment of an overpayment made to or on behalf of another person is denied the opportunity for waiver of adjustment or recovery if the overpaid person was at fault, even though he himself is without fault and otherwise meets all conditions for waiver. The first part of this proposal, which would authorize the Secretary to recover an overpayment with respect to one person (regardless of whether he is dead or alive) by withholding benefits of another who is getting benefits on the same earnings record as the overpaid person, would result in more instances than under present law where people who are liable for repayment of overpayments made to or on behalf of others would have no opportunity to have recovery waived.

Under the proposal, 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 adjustment or recovery if he is without fault and if adjustment or recovery would defeat the purpose of title II or the Railroad Retirement Act, or would be against equity and good conscience.

Underpayments

A provision of present law enacted in 1939 provides that where "an error has been made" resulting in an underpayment to a beneficiary who has subsequently died, the underpayment is to be paid by increasing the subsequent benefits of others getting benefits on the same earnings record as the deceased. Since the law did not (and does not now) contain any provision for the disposition of underpayments in death cases where there are no subsequent benefits payable, policies were developed in conjunction with the General Accounting Office and regulations were issued to define procedures for settling such underpayments. In the absence of complete and specific statutory authority for the settlement of underpayments, these administrative procedures have been challenged in several court cases. A 1949 case forced the Social Security Administration and the General Accounting Office to make a distinction between cases where a check had been properly issued but had not been cashed by the beneficiary before his death, on the ground that no "error" had been made, and cases where, though the payment was due, no check had yet been issued.

In a case decided last year, *Guarino* v. *Celebrezze*, the court held that, even in cases where a check has not been issued, in the absence of an *actual* error the provisions in present law for settling underpayments do not govern. *The court stated that nonpayment is not an "error." Since most underpayments do not involve mistakes,* it would seem to be necessary, in the absence of a change in the law, to further revise the procedures for settling underpayments. Moreover, it appears from court opinions that the question will have to be resolved by providing for payment to the estate rather than to subsequent beneficiaries in more instances than under present procedures. The procedure for paying the estate is much more complex and cumbersome than the

procedure for merely adding the amount of the underpayment to subsequent benefits payable on the same earnings record.

In order to simplify the procedures for settling underpayments and to make it possible to handle underpayments without the threat of adverse court decisions, this proposal would provide specific statutory authority for the Social Security Administration to settle underpayment.

There would be no additional cost to the program as a result of these changes.

V. PUBLIC ASSISTANCE

A. Extension of Time for State To Comply With New Requirements Relating to Provision of Medical Assistance

TEXT

On page 58, line 22, page 59, line 20, page 60, line 14, page 129, line 6, page 135, line 24, page 282, line 19, and page 296, line 21, strike out "July 1, 1967" and insert in lieu thereof "January 1, 1968".

On page 59, line 23, strike out "July 1967" and insert in lieu thereof "January 1968".

On page 145, line 4, strike out "June 30, 1967" and insert in lieu thereof "December 31, 1967".

JUSTIFICATION

H.R. 6675 gives States until July 1, 1967, to have in effect a plan under title XIX—Medical Assistance—if they are to continue to make, with Federal participation, vendor payments for medical care. It also imposes on that date certain minimum requirements as to persons included in the plan and services that must be provided under it. Many States will need action by their legislatures to effect these changes.

It has been pointed out that many 1965 legislative sessions are drawing to a close and that 1967 will be the first opportunity that some States will have to consider needed legislation. Such States are faced with a difficult if not impossible situation to get legislation enacted and a State plan developed and in operation by July 1, 1967. The proposed amendment would accordingly give States another 6 months to comply with the new requirements by advancing the relevant dates from July 1, 1967, to January 1, 1968.

B. Elimination of Separate Requirements in Relation to Tuberculous Patients

TEXT

On page 132, line 22, page 137, line 23, page 154, line 8, page 156, lines 11 and 12, page 158, line 24, and page 161, line 9, strike out "tuberculosis or".

On page 133, lines 1 and 2, page 154, lines 11 and 12, and page 159, lines 3 and 4, strike out "or tuberculosis (as the case may be)".

JUSTIFICATION

As a part of the amendment adopted by the Senate last year and incorporated in H.R. 6675 the restrictions were relaxed on Federal

matching of expenditures for aged persons in institutions for mental diseases or tuberculosis and for persons in other hospitals following a diagnosis of tuberculosis or psychosis. Most of the safeguards designed to insure improved care were made applicable to both groups. Subsequent study indicates that the number of aged, tuberculous patients is so small that with present methods of treatment special safeguards were not necessary for this group.

The amendment would accordingly leave the safeguards fully applicable to the mentally ill but would simply eliminate restrictions on the treatment of tuberculosis in general hospitals or of the aged persons with tuberculosis who are in specialized institutions. These patients would then be in the same situation exactly as anyone in a hospital for any other illness.

C. Federal Participation in Cost of Training Professional Medical Personnel

TEXT

On page 137, line 11, after "compensation" insert "or training".

JUSTIFICATION

In developing H.R. 6675 the Ways and Means Committee concluded that, since the program was primarily one of medical assistance, provisions for social services and training like those in the other public assistance titles of the Social Security Act were unnecessary and inappropriate. Such provisions accordingly were not included in the bill. As a result, the bill omits authorization for training of health personnel to work in the medical assistance program. However, authorization for this training does not exist in the other public assistance title.

The amendment would correct this defect by including authorization for Federal participation in the cost of training along with the separate provision for participating in the compensation of professional medical personnel and staff directly supporting them. In this context it would be clear that the training authority is intended to apply only to health personnel.

D. Medical Care and Services Substituted for Medical Assistance; Comparability Not Required for Services in Tuberculosis or Mental Institutions

TEXT

On page 127, line 15, after "provide that" insert "(except as to care and services described in paragraph (14) of section 1905(a))".

On page 127, line 23, page 128, line 1, and page 128, lines 8 and 15, strike out "assistance" and insert "care and services" and on page 128, line 1, strike out "is" and insert "are" and on page 128, line 7, after "provide" insert "(except as to care and services described in paragraph (14) of section 1905(a))".

On page 142, lines 21 and 24, after "services" insert "(other than services in an institution for tuberculosis or mental diseases)".

On page 143, line 17, strike out "and" at the end of the line.

On page 143, between lines 17 and 18, insert the following new paragraph:

(14) inpatient hospital services and skilled nursing home services in an institution for tuberculosis or mental diseases; and

On page 143, line 18, strike out "(14)" and insert in lieu thereof "(15)".

JUSTIFICATION

Amendments beginning on page 127 and down through page 143 should be considered as a group.

The new title XIX defines "medical assistance" as payment for care and services furnished to specified classes of individuals—persons age 65 or older, dependent children, etc. Some of the requirements in the bill for an approved State plan, e.g., the comparability of the care and services provided for various groups of individuals, use the term "medical assistance" when some or all of the persons involved are not those included in the definition. This group of amendments would, for this reason, change the term "medical assistance" in those instances to "medical care and services".

Among the requirements for approval of State plans under the new title XIX is one for comparability of services among various groups of recipients (mentioned above) and another requring provision of recipients (mentioned above) and another requiring provision of inpatient hospital services, physician services, and several other specified types of services by July 1, 1967. This group of amendments would also make it clear that such requirements don't apply in the case of services in institutions for tuberculosis or mental diseases; Federal financial participation is authorized only with respect to those age 65 or older and, therefore, applying this requirement to such services would not be appropriate at this time.

The amendments would exclude from "inpatient hospital services" and "skilled nursing home services" (which are part of the definition of medical assistance) services provided in tuberculosis or mental institutions and would list separately such services provided in institutions for tuberculosis or mental diseases. This change would help make clear that it is optional, rather than mandatory, for a State to include such services for aged individuals under its plan.

E. Authorization of Protective Payments for the Blind and Disabled Under Titles X and XIV of the Social Security Act

TEXT

On page 274, between lines 9 and 10, insert the following:

(c) Section 1006 of the Social Security Act (as amended by section 221 of this Act) is amended by adding at the end thereof the following new sentence: "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 ac-

cordance 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 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 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."

(d) Section 1405 of the Social Security Act (as amended by section 221 of this Act) is amended by adding at the end thereof the following new sentence: "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 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 aid to the permanently and totally disabled to be paid (and in conjunction with other income and re-

sources), 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."

On page 274, line 10, strike out "(c)" and insert in lieu thereof "(e)".

On page 274, line 12, insert ", X, XIV," after "title I".

JUSTIFICATION

Originally the Social Security Act authorized only money payments to public assistance recipients. Such payments could also be made to a legal guardian where one exists. Since 1950 the act has also authorized payments for medical care on behalf of public assistance recipients. In 1958 a Senate amendment was enacted which authorized not only legal guardians but legal representatives to receive money payments. As part of the Public Welfare Amendments of 1962 the Congress authorized protective payments to be made under safeguards to another individual concerned with the welfare of a recipient who, because of physical or mental incapacity, was unable to handle money. The 1962 amendments limited this provision to recipients of aid to families with dependent children.

H.R. 6675 would extend protective payment provisions and apply safeguards surrounding them to aged persons receiving assistance under title I of the Social Security Act and to the aged, blind, and disabled persons receiving assistance under title XVI. The proposed amendment to the bill would include the same provisions in the separate programs of aid to the blind and aid to the permanently and totally disabled administered under titles X and XIV of the act, thereby making all the public assistance titles the same in this respect.

F. TIME LIMITATION FOR GIVING STATE NOTICE OF HEARING ON PUBLIC ASSISTANCE ISSUES AND SCOPE OF JUDICIAL REVIEW

TEXT

On page 276, line 2, strike out "Upon" and insert in lieu thereof "Within 30 days after".

On page 276, line 15, strike out "notice" and insert in lieu thereof "it has been notified".

On page 276, lines 24 and 25, and page 277, lines 6 and 7, strike out "unless substantially contrary to the weight of the evidence" and insert in lieu thereof "if supported by substantial evidence".

JUSTIFICATION

The judicial review provision included in the House-passed bill sets time limits on virtually all steps of the process by which a State may appeal to court. In one instance, however, no time limit is set. This is the period between the Secretary's receipt of the State's request for hearing and the sending of a notice setting the time and place of such hearing to the State. The amendment would set a 30-day time limit that may elapse at this point.

The judicial review provision also uses "unless substantially contrary to the weight of the evidence" as the standard for determining whether the administrative findings of fact are conclusive. Virtually all of our grant-in-aid statutes, as well as the Administrative Procedure Act, to use the more commonly accepted phrase which the amendment here recommended would substitute.

G. Description of Standards and Procedures a State Will Use To Assure High Quality Medical Care

TEXT

On page 134, line 11, strike out "and".

On page 134, line 20, strike out the period and insert in lieu thereof "; and", and between lines 20 and 21 insert the following new paragraph:

> "(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 care and services provided to recipients of medical assistance are of high quality."

JUSTIFICATION

Title XIX includes a number of requirements that States establish standards and enter into cooperative arrangements between State agencies in the operation of their medical assistance plans. Utilization of professional medical personnel in the administration of a plan is also required. In order to insure consistency and to set forth clearly the various elements which a State will use to assure a high quality of medical care under its plan, the proposed amendment would require 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. The 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.

H. INCOME DISREGARDED UNDER ONE PUBLIC ASSISTANCE TITLE TO BE DISREGARDED ALSO UNDER OTHER PUBLIC ASSISTANCE TITLES

TEXT

On page 145, strike out lines 8 through 16 and insert in lieu thereof the following paragraph:

> (2) Section 1109 of such Act is amended to read: "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."

JUSTIFICATION

Existing law (sec. 1109) requires that when income is exempted in determining 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 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. H.R. 6675 extends this principle to the new Title XIX—Medical Assistance. The proposed amendment would make the principle applicable to all public assistance programs. This is desirable since a number of earnings exemptions are now required or authorized under the various public assistance titles.

PART TWO—MINOR SUBSTANTIVE TECHNICAL AND CLARIFYING AMENDMENTS

I. HEALTH INSURANCE

A. Beginning Date of Enrollment Period and Coverage Period

On page 43, lines 2 and 3, strike out "the first day of the second month which begins after".

TEXT

On page 43, strike out lines 21 through 25 and insert in lieu thereof.

"(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 second 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.

JUSTIFICATION

The change on page 43, lines 2 and 3, would facilitate administration of the supplementary health insurance program by advancing to the date of enactment the time during which a person eligible to enroll may enroll. This change would provide at least 1 additional month during which applications could be taken. The proposed insert in lieu of lines 21 through 25 of page 43 would permit supplementary health insurance to become effective in the month the individual attains age 65 if he enrolls in any of the 3 prior months, and is otherwise eligible. If he enrolls in the month in which he attains 65, coverage would be effective with the beginning of the following month. In the case of an individual who files 1 month thereafter his coverage would be effective for and after the second month following his enrollment month. If he delays longer than 1 month, his coverage would be effective for and after the third month following his enrollment month.

B. ADVANCING THE TIME OF APPROPRIATION OF FUNDS FOR PAYMENTS TO SUPPLEMENTARY HEALTH INSURANCE TRUST FUND FOR CONTINGENCY RESERVE

TEXT

On page 62, lines 13 and 14, strike out "during the fiscal year ending June 30, 1966".

On page 62, line 16, strike out "the next fiscal year" and insert in lieu thereof "the fiscal year ending June 30, 1967,".

JUSTIFICATION

The changes would amend a provision in the bill which deals with the reserve contingency advance for supplementary insurance. The changes are needed to provide greater flexibility as to the time of appropriation by authorizing it to be made at the beginning of the fiscal year 1966, at any time during such fiscal year, or shortly thereafter.

C. ALLOW PAYMENT OF AMOUNT APPROPRIATED FOR NONINSURED AT THE BEGINNING OF THE FISCAL YEAR

TEXT

On page 109, line 25, insert "for any fiscal year" before the comma.

On page 110, line 1, insert "or to be made during such fiscal year" after "payments made".

On page 110, line 7, insert "or expected to result" before "therefrom".

On page 110, line 10, insert "at the end of such fiscal year" after "the same position".

JUSTIFICATION

The changes would amend a provision in the bill which deals with payments from the general fund of the Treasury for noninsured persons eligible under the transitional insured status provision. The proposed changes would allow payment of the full amount appropriated for a fiscal year at the beginning of the fiscal year as well as during such year.

D. PROVIDE THAT AN EMPLOYING AGENCY OF CERTIFYING OR DISBURSING OFFICER WOULD BE EXCUSED FROM LIABILITY WHEN SUCH OFFICER IS EXCUSED

TEXT

On page 26, between lines 7 and 8, insert the following new paragraph:

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

On page 57, after line 25, insert the following new paragraph:

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

JUSTIFICATION

The changes are needed in order to provide agencies and organizations authorized to make payments under part A and carriers authorized to make payments under part B with the same immunity from liability for incorrect payments as would be provided their certifying and disburing officers.

E. Deletion of Specification of Only Some of the Services Included as Diagnostic Tests Under "Medical and Other Health Services".

TEXT

On page 82, strike out lines 15, 16, and 17 and insert in lieu thereof the following;

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

JUSTIFICATION

The proposed change would simplify and clarify the provision covering diagnostic and laboratory tests under part B by deleting the mention of some but not all of the tests for which payments could be made.

F. Individual Not To Be Considered Discharged From An Extended Care Facility if Admitted to Same or Any Other Such Facility Within 14 Days

On page 71, lines 24 and 25, strike out "if readmitted thereto within 14 days after discharge therefrom" and insert in lieu thereof—

if, within 14 days after discharge therefrom, he is admitted to such facility or any other extended care facility

JUSTIFICATION

The bill now provides that an individual discharged from an extended care facility will be deemed not to have been discharged if he is readmitted to the same facility within 14 days. In some cases, a bed may not be available when he needs to return. The proposed change is needed to permit the person to go to some other participating facility.

G. Advance Filing of Applications for Hospital Insurance Benefits by Noninsured

TEXT

On page 109, line 1, insert "more than 3 months" after "filed by an individual".

JUSTIFICATION

The change on page 109, line 1, is needed because without this change an uninsured person, who is made eligible for hospital insurance benefits under part A, and who attains age 65 in September 1966, for example, could enroll under the supplementary insurance plan in

June 1966 but would have to be told to come back again in September 1966 to file another application for hospital insurance under the basic plan, since no advance filing by such an individual is provided for under the bill. The change would permit applications for part A coverage by such individuals also to be made in advance and thus would facilitate administration.

II. OASDI

A. Clarifying Changes in Provision Relating to the Adoption of a Child by an Old-Age Insurance Beneficiary

TEXT

On page 261, line 8, after "such individual" insert "adopted after such individual became entitled to such disability insurance benefits".

On page 261, line 21, before the comma insert—

> (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)

On page 262, strike out lines 1 and 2 and insert in lieu thereof—

> paragraph (9)) who adopts a child after such individual becomes entitled to such benefits, clause (i) of paragraph (1)(C) shall not apply to such child unless such

JUSTIFICATION

The change on page 261, line 8, and the changes on page 262, lines 1 and 2, amend a provision in the bill which imposes new eligibility requirements upon children who are adopted after the worker becomes entitled to old-age insurance benefits or disability insurance benefits. The changes are needed to limit the application of the new requirements to cases in which the child is adopted *after* the worker becomes entitled to the benefits.

The change on page 261, line 21, is needed because under H.R. 6675 a period of disability terminates when the worker becomes 65. Without this change there would be cases where a child who met all of the requirements could not become entitled to benefits because the period of disability which existed up to age 65 would not exist at the time of the adoption.

B. Addition to Provision Relating to the Change in the Definition of Disability To Provide for Continuation of Life of Applications of Dependents of New Disability Insurance Beneficiaries

TEXT

On page 182, line 21, after the period insert the following new sentence:

> The provisions of the preceding sentence shall also be applicable in the case of applications for monthly insurance benefits under title II of the Social Security Act based on the wages and self-employment income of an applicant with

respect to whose application for disability insurance benefits under section 223 of such Act subparagraph (B)(i) or (ii) of the preceding sentence is applicable.

JUSTIFICATION

The addition page 182, line 21, amends a provision in the bill which permits an application for disability insurance benefits filed prior to the month of enactment to be effective for benefits under the new law if the applicant did not die prior to such month and notice of the final decision on such previous application has not been given. Since the provision is applicable only to applications for disability insurance benefits and periods of disability, the addition is needed to include applications by dependents filed on the earnings record of a disabled worker. Without this addition, there would be cases in which benefits would be payable to a worker based on a previously filed application but not to his wife and children for some months because they do not have effective applications under the new law, even though they may all have filed on the same date.

C. Qualification of Divorced Wife for Widow's Benefits

TEXT

Page 209, line 3, insert before the comma:

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

JUSTIFICATION

This change would clarify the provision to assure that in every case a woman age 62 or over who is entitled to wife's benefits as a divorced wife can become entitled to widow's benefits as a surviving divorced wife. If the change were not made a woman who qualified for wife's benefits and whose wife's benefits did not terminate when she later became divorced (after having been married for 20 years) would have to meet the special support requirements added by section 308 to qualify for widow's benefits. Her wife's benefits would terminate with the death of her former husband and as a result she could not get widow's benefits unless she could show that at the time her husband became entitled to benefits (while she was married to him) or at the time he died she was receiving from him at least half of her support or substantial contributions toward her support or there was a court order for such contributions.

D. Provision To Avoid an Increase in the Family Maximum for Some Families Solely Because of Entitlement of a Child Attending School

TEXT

On page 167, lines 3 and 15, after "person" insert—

(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)

JUSTIFICATION

The change on page 167, line 3 and line 15, is needed because without this change a child who applies for benefits under the provisions of section 306 of the bill *in* the month of enactment could, in cases where the family maximum is applicable, get more in benefits than would be payable if he delayed his application until a later month. This problem arose when the new provisions for a child age 18 or over (sec. 306 of the bill) were made retroactive to January 1965. There was no intent to increase the family maximum applicable in case of families entitled to benefits for the month of enactment or any prior month by including the benefit of a child over 18 who becomes entitled to a benefit for any such month by reason of the new provisions under an application filed in the month of enactment of the bill. A premium should not be put on filing in a particular month. Section 302(a)(2) should apply in the month of enactment, as it does now, for other people on the rolls, but the benefit of a child entitled as a result of section 306 of the bill should be excluded from "the sum of the benefits" which is increased under the bill and applies as the new family maximum.

EXAMPLE

A widow and one child are on the benefit rolls in January 1965. Their benefits are based on a present law PIA of $102. (The family maximum of $228.80 does not apply with only two people on the rolls.) In January they were paid $76.50 each. In June 1965, H.R. 6675 is enacted and a child, age 20, applies for benefits in that month. As the bill is now written, their benefits would be as follows:

NEW PIA, $109.20—FAMILY MAXIMUM, $228.80

A lump sum check for retroactive benefits would be paid to the 20-year-old child (assuming he was entitled as of January 1965).[1] The amount would be $379 (family maximum $228.80 minus $153 (two times $76.50) equals $75.80 per month—for 5 months (January–May) totals $379). For June, this child is entitled without the application of section 202(j)(1) and the benefits for the family for June and future months would be—

	Original under present law	Adjusted	Increased, 107 percent
Widow	$76.50	$76.30	$81.70
Child	76.50	76.30	81.70
Do	76.50	76.30	81.70
Total		228.90	245.10

[1] Residual payment to family maximum for retroactive months (sec. 202(j)(1) and sec. 203(a)(2), as amended).

If the older child had waited until July to apply for benefits, the family's regular monthly benefits would be as follows:

	Original benefit	Adjusted benefit
Widow	$81.90	$76.30
Child	81.90	76.30
Do	81.90	76.30
Total		228.90

E. Repeal of a Recomputation Provision no Longer Needed

TEXT

On page 176, between lines 9 and 10, insert the following new paragraph:

> (7) Effective January 2, 1966, subparagraph (B) of section 102(f)(2) of the Social Security Amendments of 1954 is repealed.

JUSTIFICATION

The change on page 176 between lines 9 and 10, repeals an old provision in the 1954 amendments (102(f)(2)(B)) for a dropout recomputation based on the acquisition of six quarters of coverage after June 1953. It was intended that this provision be repealed when the reference in section 215(b)(5) of present law was deleted by section 302(a)(3) of the bill, but through oversight the repeal provision was omitted. It would be rare for a person (who would now be over age 75) who has not qualified for a dropout recomputation over the past years to finally acquire his sixth quarter of coverage after 1965 and qualify under this provision.

F. Additional Point for Conversion of a Disability Insurance Benefit to an Old-Age Insurance Benefit

TEXT

On page 181, between lines 17 and 18, insert the following new subsection:

> (e) So much of section 215(a)(4) of such Act as precedes "the amount in column IV" is amended to read as follows:
>
> "(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,".

On page 181, line 18, strike out "(e)" and insert in lieu thereof "(f)".

On page 183, between lines 20 and 21, insert the following new paragraph:

(5) The amendment made by subsection (e) shall apply in the case of the primary insurance amounts of individuals who attain age 65 after the enactment of this Act.

On page 188, strike out lines 7 and 8, insert in lieu thereof:

(k) Section 215(a)(4) of such Act is amended by striking out "such dis-

JUSTIFICATION

The new paragraph (e) inserted between lines 17 and 18 on page 181 to change section 215(a)(4) of the act is needed because of the new definition of disability that would be provided by section 303 of the bill. Without the change in section 215, there would be no way to convert the benefit of a woman who meets the new definition immediately upon enactment of the bill. The change is essential in subparagraph (A) of section 215(a)(4); since a similar change in subparagraph (B) is appropriate and would make the 2 subparagraphs the same, they are combined into one paragraph.

The change on page 181, line 18, is a conforming change.

The change on page 183, between lines 20 and 21, provides the effective date for the change on page 181.

The change on page 188, lines 7 and 8, is needed in order to eliminate a reference to "clause (B)" which, as explained above in connection with the change on page 181, has been eliminated.

EXAMPLE

A woman reaches age 62 in January 1965 and applies for an OAIB (old-age insurance benefit). Nine years are used in the computation of the PIA (primary insurance amount on which the OAIB is based).

H.R. 6675 is enacted in June 1965. She meets the new definition of disability (sec. 303 of the bill), files for DIB (disability insurance benefits) in July 1965, and her disability is established as of June 1963. Her waiting period begins January 1964, when she is deemed to be age 62. Her DIB computation can be based on 7 years (out of the period 1951 to 1963, inclusive) with earnings in the disability period excluded, or on 8 years out of the period 1951–64 inclusive. Her DIB is based on the 8-year computation using 1964 since this is better for her.

She attains age 65 in January 1968—ending her period of disability. Under section 215(a)(4), her DIB is converted to an OAIB when she "became entitled to an OAIB." Since she was *previously* entitled to an OAIB, her PIA for this benefit must be based on (*a*) the 9 years used originally or (*b*) the 7-year computation (out of the period 1951–63). Either of these periods gives a lower PIA than the 8-year computation on which her DIB is based. There is no way under present law to use the 8 years—converting the DIB to an OAIB. *If* a *third* computation point—attainment of age 65—were provided, this problem would not occur. Hence, the change on page 181.

G. Provision To Authorize Procedures Whereby the Surviving Payee of a Combined Social Security Benefit Check Could Be Paid the Amount of the Check Issued for the Month in Which the Other Payee Died, on the Condition that any Resulting Overpayment Would Be Recovered

TEXT

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications, and the new section 329, relating to overpayments and underpayments), insert the following new section:

PAYMENTS TO TWO OR MORE INDIVIDUALS OF THE SAME FAMILY

SEC. 330. Section 205(n) of the Social Security Act is amended to read as follows:

"(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 surving 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."

JUSTIFICATION

Present procedures require that when one payee of a combined social security benefit check dies, the check issued for the month in which death occurs shall be returned to the Treasury Department for cancellation, and that another check shall be issued to the surviving beneficiary in payment of the particular benefit to which that beneficiary is entitled for the month. The delay involved in this procedure frequently results in hardship for the survivor. This hardship might be avoided if procedures were worked out whereby the surviving beneficiary could be 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 (unlike checks for previous months) represent an overpayment—legislative authority is needed for making such temporary overpayments.

The proposal 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. The overpayment resulting from the cashing of the combined check would be

recovered through the adjustment procedures now in the law. Specific procedures for cashing the check and for recovery of the overpayment would be spelled out in regulations of the Secretary of the Treasury.

There would be no cost to the program as a result of this change.

H. Validation of Certain Erroneously Reported Wages of Some Employees of Nonprofit Organizations Who Have Filed Waiver Certificates for OASDI Coverage

TEXT

On page 235, between lines 7 and 8, insert the following new subsection:

(d) If—

(1) an individual performed service with respect to which remuneration was paid before the date of enactment of this Act by an organization which, before such date, filed a waiver certificate pursuant to section 3121(k)(1) of the Internal Revenue Code,

(2) such service is excluded from employment under title II of the Social Security Act but would not be excluded therefrom if the requirements of such section 3121(k)(1) had been met with respect to such service,

(3) such service was performed during the period such certificate was in effect, and

(4) such individual was listed pursuant to such section 3121(k)(1) at any time during such period and before the date of enactment of this Act as an employee who concurred in the filing of such certificate or such individual filed a request for coverage pursuant to section 105(b) of the Social Security Amendments of 1960, as in effect prior to the enactment of this Act (but such listing or request was not effective with respect to the service described above),

then, subject to the conditions stated in subparagraphs (B), (C), (D), and (E) of paragraph (1), and paragraph (4), of section 105(b) of the Social Security Amendments of 1960, as amended by this section, the remuneration of such individual which was paid with respect to such excluded service shall be deemed to constitute remuneration for employment for purposes of such title II.

JUSTIFICATION

Employees of nonprofit organizations can be covered under the social security system only if the organization files a waiver certificate in accordance with section 3121(k) of the Internal Revenue Code. If such a certificate is filed, then all current employees who sign a list at that time (it may be amended to include additional names for a period of 2 years thereafter), or who are employed after the filing of the certificate, are covered for social security purposes.

From time to time in the past organizations which have failed to meet all the requirements of section 3121(k) of the Internal Revenue Code with respect to some or all of their employees, but which have

paid the taxes due with respect to the remuneration of the employees not fully covered as a result of the failure, have been given an opportunity to rectify their omissions or other errors prospectively or retroactively, or both, through the enactment of special provisions of law. (The present bill includes one such provision, although, hopefully, the enactment of the bill, which also includes a provision permitting the waiver certificate filed under section 3121(k) of the Internal Revenue Code to be made retroactive (at the option of the organization) for up to 5 years, should all but completely eliminate the need for such special provisions in the future.)

Though the Social Security Amendments of 1960 permitted many organizations to rectify their past errors under section 3121(k), we have learned of at least one case—and there may well be others—where the organization made further errors in attempting to provide social security coverage for its employees through the use of the provisions of the amendments. As a result of these errors, the attempt to gain coverage for such employees was ineffective for part of the period of their employment. Their services both before and after this noncovered period were effectively covered for social security purposes. The change here recommended in the bill would enable this organization, and any others in similar circumstances, to rectify this further, unintentional, error on their part and remove this gap in the coverage of some of their employees.

III. PUBLIC ASSISTANCE

A. Social Security Payments To Be Disregarded by the State in Determining Need

TEXT

On page 281, strike out lines 12 through 14, and insert the following:
Act, any amount paid to any individual under title II of such Act (or under the Railroad Retirement Act of 1937 by reason of section 326(a) of this Act), for any one or more months which occur after December 1964 and before the third month following the month in which this Act is enacted, to the extent that such payment is

JUSTIFICATION

Section 406 of the bill would authorize the States to disregard, in determining the need for aid or assistance under the Federal-State public assistance programs, any payment for months prior to the month it is received which is attributable to the OASDI benefit increase or the newly authorized benefits for children age 18 to 22 attending school. The amendment on page 281 would make it clear that this section is intended only to take care of cases where the payments for prior months are due to the provision in the bill making the benefit increase and these new children's benefits retroactive to January 1, 1965. As drafted, this section of the bill is not clearly confined to such payments, as it unquestionably was intended to be. The revision would make it clear that this section applies only to payments covering a period of 1 or more months before the month

in which the payment is made, and which occur after December 1964 and before the third month following the month in which the bill is enacted.

The Social Security Administration indicates that if the bill is enacted during the first 15 days of a month the first regular monthly check reflecting the benefit increase (or including the regular payment for children over 18) will most likely be the check for the second month following the month of enactment. This check would be mailed to the beneficiaries for receipt on the third day of the next month, i.e., the third month following the month of enactment. The lump-sum check covering retroactive payment fo the benefit increase (or retroactive benefits for children over 18) would be mailed during the second month following the month of enactment and would cover the increase through the month following the month of enactment.

If enactment is delayed until after the 15th of a month, the first regular check would be the one for the third month after enactment (mailed in the fourth month) and the lump-sum retroactive check would be mailed in the third month after the month of enactment (to include payments through the second month). The proposed revision would cover such retroactive checks.

The Ways and Means Committee, while clearly not intending to cover retroactive payments which are *not* related to the provision of the bill making the benefit increase and the benefits for children over 18 retroactive to January 1, 1965, did intend to cover all payments which were so related, including payments covering this 1- or 2-month period after enactment; otherwise the States would be required to make a distinction between the portion of the retroactive check which covers months after the month of enactment and the portion thereof which covers months up through the month of enactment.

O