H.R. REP. 92-231, H.R. Rep. No. 231, 92ND Cong., 2ND Sess. 1972, 1972 U.S.C.C.A.N. 4989, 1971 WL 11290
(Leg.Hist.)

***4989** P.L. 92-603, **SOCIAL SECURITY AMENDMENTS** OF 1972

House Report (Ways and Means Committee) No. 92-231,
May 26, 1971 (To accompany H.R. 1)
Senate Report (Finance Committee) No. 92-1230,
Sept. 26, 1972 (To accompany H.R. 1)
House Conference Report No. 92-1605,
Oct. 14, 1972 (To accompany H.R. 1)
Cong. Record Vol. 117 (1971)
Cong. Record Vol. 118 (1972)
DATES OF CONSIDERATION AND PASSAGE
House June 22, 1971; October 17, 1972
Senate October 5, 6, 17, 1972

The House Report and the Conference Report are set out.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE REPORT NO. 92-231

May 26, 1971

THE Committee on Ways and Means, to whom was referred the bill (H.R. 1) to amend the Social Security Act to provide increases in benefits improve computation methods, and raise the earnings base under the OASDI program to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis on improvements in their operating effectiveness, to authorize a family assistance plan providing basic benefits to low-income families with children with incentives for employment and training to improve the capacity for employment of members of such families, to achieve more uniform treatment of recipients under the Federal-State public assistance programs and otherwise improve such programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

The amendment to the text of the bill strikes out all after the enacting clause and inserts a substitute which appears in the reported bill in italic type.

The committee also has amended the title of the bill to conform to the changes made in the text.

I. PRINCIPAL PURPOSES AND SCOPE OF THE BILL

The proposals embodied in H.R. 1 as reported by your committee would make a number of changes and improvements in the provisions of the Social Security Act relating to the old-age, survivors, and disability insurance program, the hospital and medical insurance program, the medical assistance program and the child welfare program. In addition, and more importantly, the bill would provide for a basic restructuring of the national welfare system by replacing the four ***4990** existing Federally-aided assistance programs by new Federal programs for needy families and for needy aged, blind or disabled persons. The bill also would modify the provisions of the Internal Revenue Code relating to the retirement income credit and deductions for child care.

THE NEED FOR WELFARE

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Your committee's proposals for welfare reform have been formulated during a period of mounting Congressional concern, both over the extraordinary growth in the welfare rolls, particularly in the aid to families with dependent children (AFDC) program, and in the nature of that growth. In the year that has just passed from the end of 1969 to the end of 1970, the number of people receiving AFDC has increased 32.1 percent and the amount of money being paid to these recipients increased 36 percent. In 1967, a year during which the Congress sought to make major changes and improvements in the welfare system by passing the **Social Security Amendments** of 1967, the amount of Federal State and local money being used for cash payments for AFDC recipients was about $2 billion. The estimate for 1972 is about $6.8 billion, or more than three times as much as was paid just five years earlier. The greatest growth in the AFDC rolls has been in that segment which represents family breakup. These are families in which there is desertion, separation, divorce and illegitimacy.

The exploding number of broken families which are becoming increasingly dependent on welfare for all their needs poses serious social problems. And, as the costs of supporting them soar, all levels of government have been confronted with difficult fiscal problems. There are now about 10 million persons receiving AFDC in the United States, about 4 million more than just two years ago. In some cities as many as one out of every 5 or 6 children are on welfare. There are some areas of cities where it is rare to find even one family which is not on welfare.

The American people have traditionally been sympathetic and willing to help those who are in need. But your committee believes that the American people do not want a system which results in promoting welfare as a way of life. Your committee's deliberation, therefore, have been aimed toward providing adequate assistance to those who cannot help themselves, while at the same time creating a system of assistance which will maximize the incentive and the obligation of those who are able to work to help themselves.

The proposals of your committee are far-reaching. For the first time, as the Administration has urged, low-income families with a working father will be eligible for cash payments. The Administration has advocated this approach in the belief that assistance to families in which the father is present and working is necessary both for fairness of treatment and for promoting greater family stability.

Thus, under the new Federal programs proposed by your committee, all needy families with children will be eligible for assistance. The aim, however, will be to move every family in which there are employable adults toward employment and economic independence. These families will be enrolled by the Department of Labor in the Opportunities for Families program designed to help people move off welfare. Other families, in which there is no employable adult, ***4991** will be enrolled in the Family Assistance Plan, under the Department of Health, Education, and Welfare.

Your committee's bill would also establish a new Federal program for the aged, blind and disabled, to be administered by the Social Security Administration.

The welfare system in the United States has been moving toward a state of crisis and chaos-- to change its direction will be difficult. The purpose of this bill is to effect that change. Your committee's bill will establish a new welfare system, based on a sympathetic understanding of the needs of the helpless, and the conviction that all those who are capable of participating in the economy of this country should have the opportunity and the responsibility of doing so. It is a system designed to be fair and rational, the kind of system which recipients deserve and taxpayers can respect.

OPPORTUNITIES FOR FAMILIES-WORK AND TRAINING FOR EMPLOYABLES

First, the bill would make basic reforms in the present program which furnishes assistance to needy families with children by establishing a mechanism to separate out applicants who are employable and send them directly to the Department of Labor for registration for work or training. This new program for employables-- the Opportunities for Families program-- emphasizes work rather than welfare dependency through the use of incentives and requirements by providing--

(1) registration for jobs or training, as a prerequisite to receiving benefits, of all able-bodied applicants (except mothers with young children);

(2) reform of current job training programs by deemphasizing institutional training which does not lead to jobs, by the creation of needed jobs through a major public service employment program, and by placing authority and responsibility for

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all aspects of the expanded work and training programs, including day care, family planning, and other supportive services, on the Secretary of Labor;

(3) a schedule of benefits and training allowances so that an individual will always have financial gain from effort expended in work or training; and

(4) penalties through loss of benefits for those who refuse to register or to accept employment, training, or vocational rehabilitation services.

FAMILY ASSISTANCE

Second, the bill would establish a Federal program of assistance for those needy families with children in which there is no employable adult-- the Family Assistance Plan to be administered by the Secretary of Health, Education, and Welfare. Individuals, who are incapacitated would be referred to vocational rehabilitation programs and required to accept such services if offered. Family planning services would be offered to appropriate family members. As soon as any family included an employable adult, the Department of Health, Education, and Welfare would transfer the family to the Department of Labor.

***4992** PAYMENT OF FAMILY BENEFITS

Third, the bill would establish greater equity in welfare payments throughout the country and would greatly improve administration of payments to families by providing--

(1) a basic Federal payment level for all needy families with children of $800 for the first two members of a family, $400 for the next three, $300 for the next two, and $200 for the next one, on an annual basis ($2,400 for a family of four);

(2) uniform eligibility requirements throughout the nation, including limitations on assets, and uniform definitions of what constitutes income for purposes of eligibility;

(3) payments to families where the father is working full-time thus eliminating inequity and the economic incentive for family breakup in the present system under which poor families in which the father is present and working are not eligible for any help;

(4) Federal administration of the payments procedures, with requirements in law which would assure that eligibility determination is both strict and fair; and

(5) that deserting parents would be held responsible for Federal payments made to their families, and that it would be a Federal crime for a parent to travel in interstate commerce to avoid supporting his child.

ASSISTANCE FOR THE AGED, BLIND AND DISABLED

Fourth, the bill would substantially improve the effectiveness of the adult assistance programs under the Social Security Act by providing--

(1) for replacing the three present State-administered programs of assistance to the aged, blind, and disabled with one combined adult assistance program which would be Federally administered by the Social Security Administration and would have nationally uniform requirements for such eligibility factors as the level and type of resources allowed and the degree of disability or blindness;

(2) that each aged, blind, or disabled adult would receive assistance sufficient to bring his total monthly income up to $130 in fiscal year 1973, $140 in fiscal year 1974, and $150 thereafter (for couples the levels would be $195 in fiscal 1973 and $200 thereafter); and

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(3) that the cost of maintaining these basic benefit levels for the aged, blind, and disabled will be borne entirely by the Federal Government.

STATE SUPPLEMENTATION AND FISCAL RELIEF

Fifth, the bill would provide for Federal administration of optional State supplementation and very substantial fiscal relief to the States and localities. Each State could, at its discretion, provide additional assistance to the aged, blind, and disabled and families with children over and above the basic Federal levels set in the bill. In addition, States could enter into agreements under which the Federal government would administer any such supplemental assistance without charge to the States for the costs of administration.

***4993** It is estimated that States would save about $1.5 billion in the first year of the program over what their expenditures would be under present law. The bill would assure each State that it could, if it wished, maintain its present levels of assistance to the needy aged, blind, disabled, and families with children (including increases to reflect the loss of food stamp eligibility) and still not have to spend more than the dollar amount it expends in calendar year 1971 for benefits to these same categories of people. This assurance provision would be effective only with respect to a fiscal year during which the State had an agreement with the Federal government to administer the supplemental payments.

CASH BENEFITS, MEDICARE AND MEDICAID

In addition to amendments designed to reform the nation's welfare system the Committee on Ways and Means has had as a principal order of business for the past several months the subject of old-age, survivors, and disability insurance and medicare and medicaid. In the course of the Committee's deliberations, an urgently needed 10-percent general increase in social security benefits, effective retroactively to January, 1971, was enacted in March of this year.

The provisions of the bill relating to the OASDI program are those which your committee believes are most urgently needed and which can be financed from available funds. The bill would provide social security beneficiaries with a 5-percent increase in benefits beginning with payments for June 1972 and a guarantee that future inflationary changes in the prices of goods and services will not erode the purchasing power of their benefits. In addition, the bill would provide improvements in the provisions of the law relating to the social security retirement test; benefits for widows, widowers, and other dependents; the method of computing benefits; the 'waiting period' for disability benefits; and minor extensions of coverage.

Your committee's bill provides for two major changes in the medicare program that will directly affect the protection afforded beneficiaries. Medicare coverage would be broadened to include persons entitled to disability benefits under the social security and railroad retirement programs, after they have been disabled for at least two years. Your committee is convinced that the unmet need for health insurance protection among the disabled of the Nation is so great that this extension of protection should not be put off any longer. Also to lessen the financial burden on beneficiaries of the rising costs of health care, the premium amount paid by persons who are enrolled in the supplementary medical insurance program would be increased only in the event of a general increase in cash benefits.

The provisions of your committee's bill dealing with the operating effectiveness of the medicare, medicaid, and maternal and child health programs should be viewed as a related set of provisions.

Your committee conducted a thorough review of the operations of the two major health programs in the Social Security Act--medicare and medicaid. These programs taken together accounted for $10 billion of the total of $67 billion which was expended for health care in the United States in fiscal year 1970. Clearly, the impact which these programs have on the health industry is quite substantial. Clearly too, developments in the health care field have a substantial impact on these programs.

***4994** Your committee is convinced that there have developed a number of serious deficiencies in the operation and administration of the present programs which need correction. Some of these deficiencies can be attributed to inadequate planning and uneven performance by the Federal Government and its agents, and the States, particularly in the early stages of these programs. Your committee has received assurances from the Department of Health, Education and Welfare that the

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strong efforts which have been made to improve the operating effectiveness of these programs will continue.

Your committee also concluded that there is no simple or single solution to the problems now existing in the health care field which adversely affect these programs. But your committee does believe that there are modifications which can and should be made in these programs-- changes which, while perhaps not very significant taken singly, as a whole, show great promise for making significant advances in accomplishing the goal of making these programs more economical and more capable of carrying out their original purposes.

The cost of the changes relating to the OASDI program and of meeting the existing actuarial deficit in the hospital insurance program would be met by increasing the earnings base to $10,200 beginning January 1972 and by revising the contribution rate schedules.

INCOME TAX CHANGES

The income tax changes included in this bill are closely associated with the social security and welfare provisions included in the bill. One of the income tax changes liberalizes the deduction for child care expenses where there is a working mother. This will be of primary benefit to those in the relatively low income levels and is in line with other provisions of this bill which provide for child care services and encourage those receiving welfare payments to obtain employment.

The second income tax change also is closely associated with the social security provisions. Social security benefit payments, upon receipt by the individual, are free of income tax, and in the past Congress had considered it appropriate to also exempt from income tax a comparable amount of income received by the elderly to the extent they do not receive social security payments. However, the provision (the retirement income credit) in existing law which is designed to achieve this result has not been updated with the changes in the social security payments in recent years. Moreover, the provision has proved to be so complex in operation that many who should be eligible for the retirement income credit have not used it. Your committee has revised the retirement income credit of present law to significantly raise the levels of income on which the credit is based and also to substantially simplify the method of computing the credit.

***4995** II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. PROVISIONS RELATING TO THE SOCIAL SECURITY CASH BENEFITS PROGRAM

Five-percent increase in social security benefits.-- Social security benefits would be increased by 5 percent. The minimum benefit would be increased from $70.40 to $74.00 a month. The average old-age insurance benefit payable for the effective month would rise from an estimated $133 to $141 a month and the average benefit for aged couples would increase from an estimated $222 to $234 a month. Special benefits for persons age 72 and over who are not insured for regular benefits would be increased from $48.30 to $50.80 for individuals and from $72.50 to $76.20 for couples, to $50.80 for individuals and from $72.50 to $76.20 for couples.

Effective date-- Benefits payable for June 1972.

Number of people affected and dollar payments.-- 27.4 million beneficiaries would become entitled to higher payments and 16,000 people would be made newly eligible. About $2.1 billion in additional benefits would be paid in the first full year. [1]

Automatic increase in benefits, the contribution and benefit base, and in the earnings test.

(a) Increases in benefits:

Social security benefits would be automatically increased according to the rise in the cost of living. Increases could occur only once a year, provided that the Consumer Price Index increased by at least 3 percent and that legislation increasing benefits had neither been enacted nor become effective in the previous year.

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(b) Increases in contribution and benefit base:

In any year in which an automatic benefit increase becomes effective, the social security contribution and benefit base would be automatically increased according to the rise in average wages covered under the social security program (if wage levels had gone up sufficiently).

(c) Change in earnings test:

In any year in which an automatic benefit increase becomes effective, the exempt amount under the retirement test would be automatically increased in the same manner as the contribution and benefit base is increased-- according to the rise in average wages covered by the program.

Effective date.-- First possible increase effective for January 1974.

Special minimum primary insurance amounts

A special minimum benefit would be provided for people who worked for 15 or more years under social security. The benefit would be equal to $5 multiplied by the number of years of coverage the person has under the social security program, up to a maximum of 30 years. The highest minimum benefit under this provision would be $150 for a person who had 30 or more years of coverage. The special minimum would not be raised under the automatic benefit increase provisions.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 300,000 people would get increased benefits on the effective date and $30 million in additional benefits would be paid in the first full year.

***4996** Increased widow's and widower's insurance benefits

A widow (or widower), including those already on the rolls, would be entitled to a benefit equal to 100 percent of the amount her deceased husband would be receiving if he were still living. Benefits applied for before age 65 would be reduced according to the widow's age at the time of application.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 3.4 million people would receive increased benefits on the effective date, and $764 million in additional benefits would be paid in the first full year.

Increased benefits for those who delay retirement beyond age 65

A worker's old-age benefit would be increased by 1 percent for each year (1/12 of 1 percent for each month) in which the worker between ages 65 and 72 does not receive benefits because he is working after age 65. No increased benefit would be paid under the provision to the worker's dependents or survivors.

Effective date.-- Prospective only for computations and recomputations after 1971 based on earnings after 1970.

Number of people affected and dollar payments.-- 400,000 people would receive increased benefits, and $11 million in additional benefits would be paid, in the first full year.

Age-62 computation point for men.

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women only years up to age 62 must be taken into account. Also,

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benefit eligibility is figured up to age 65 for men and up to age 62 for women. Under the bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

The new provision would become effective over a 3-year transition period. The number of years used in computing benefits for men would be reduced in three steps. Men who reach age 62 in 1972 would have only years up to age 64 taken into account; men who reach age 62 in 1973 would have only years up to age 62 taken into account; men reaching age 62 in 1974 or later would have only years up to age 62 taken into account in determining average earnings. The number of quarters of coverage needed for insured status for men would also be reduced in three steps, with the first step in the reduction effective for January 1972 and subsequent reductions in 1973 and 1974.

Effective date.-- Prospective only, in 3 manual steps, becoming fully effective for men reaching 62 in 1974 and after.

Dollar payments.-- $6 million in additional benefits would be paid in the first full year.

Additional dropout years

One additional year of low earnings-- in addition to the 5 years provided under present law-- for each 15 years of covered work could be dropped in computing the average monthly wage on which benefit amounts are based.

Effective date.-- Benefits payable on the basis of the earnings of people who reach age 62 or die after 1971 or whose first month of entitlement to disability insurance benefits is after December 1971.

Dollar payments.-- $17 million in additional benefits would be paid in the first full year.

***4997** Election to receive actuarially reduced benefits in one category not to be applicable to certain benefits in other categories.

Under present law, when a person receives a benefit in one benefit category that is reduced because it is taken before age 65, and also receives another benefit in a different benefit category beginning with the same month or a later month, the second benefit is generally reduced to reflect the reduction in the first benefit. For example, when a woman applies for a retirement benefit prior to age 65, it is reduced under the actuarial reduction formula; if she applies for a spouse's benefit at age 65 or later, it is reduced to take account of the fact that she took her retirement benefit early. The bill would eliminate the actuarial reduction of the spouse's benefit in such cases. The same rule would apply to men entitled to dependent husbands' benefits.

Effective date.-- The sixth month following the month of enactment.

Number of people affected and dollar payments.-- 100,000 people would receive increased benefits on the effective date, and $20 million in additional benefits would be paid in the first full year.

Computation of benefits based on combined earnings

A working married couple each of whom had at least 20 years of covered earnings under the program after marriage could have their earnings for each year combined up to the maximum amount of taxable earnings for that year. If they elected to have their earnings combined, each member would receive a benefit equal to 75 percent of the benefit based on their combined earnings. Payments to the surviving spouse based on the combined earnings would continue at the 75-percent rate. Dependents' and other survivors' benefits would not be affected. The provision would be an alternative to present law and would apply only if higher payments would result.

Effective date.-- Prospective only for people who attain age 62 in or after January 1972.

Dollar payments.-- $11 million in additional benefits would be paid in the first full year.

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Liberalization of the retirement test

The amount that a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $1,680 to $2,000. Under present law, benefits are reduced by $1 for each $2 of earnings between $1680 and $2880 and reduced by $1 for each $2 of earnings between $1680 and $2880 and for each $1 of earnings above $2880. The bill would provide for a $1 reduction for each $2 of all earnings above $2000; there would be no $1-for-$1 reduction as under present law. Also, in the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included, as under present law, in determining his total earnings for the year.

Effective date.-- Taxable years ending after 1971.

Number of people affected and dollar payments.-- In the first full year, 700,000 people would receive increased payments and 390,000 people who get no payments under present law could get some payments. Additional benefits amounting to $484 million would be paid in the first full year.

Reduced benefits for widowers at age 60

Widowers under age 62 could be paid reduced benefits (on the same basis as widows under present law) starting as early as age 60.

Effective date.-- January 1972.

***4998** Childhood disability benefits

Childhood disability benefits would be paid to the disabled child of an insured retired, deceased, or disabled worker, if the disability began before age 22, rather than before 18 as under present law. In addition, a person who was entitled to childhood disability benefits could become re-entitled if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 13,000 additional people would become immediately eligible for benefits on the effective date, and $14 million in additional benefits would be paid in the first full year.

Continuation of student's benefits through end of semester

Payment of benefits to a child attending school would continue through the end of the semester or quarter in which the student (including a student in a vocational school) attains age 22 (rather than the month before he attains age 22) if he has not received, or completed the requirements for, a bachelor's degree from a college or university.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 55,000 students would have their benefits continued beyond age 22, and $16 million in additional benefits would be paid, in the first full year.

Benefit-eligibility requirements for a child adopted by an old-age or disability insurance beneficiary

The provisions of present law relating to eligibility requirements for child's benefits in the case of adoption by old-age and disability insurance beneficiaries would be modified to make the requirements uniform in both cases. A child adopted after a retired or disabled worker becomes entitled to benefits would be eligible for child's benefits based on the worker's earnings if the child is the natural child or stepchild of the worker or if (1) the adoption was decreed by a court of competent jurisdiction within the United States, (2) the child lived with the worker in the United States for the year before the worker became

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disabled or entitled to an old-age or disability insurance benefit, (3) the child received at least one-half of his support from the worker for that year, and (4) the child was under age 18 at the time he began living with the worker.

Effective date.-- January 1968.

Nontermination of child's benefits by reason of adoption

A child's benefit would no longer stop when the child is adopted.

Effective date.-- Month of enactment.

Elimination of the support requirements for divorced women

Under present law, benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 20 years before the divorce, and to a surviving divorced mother. In order to qualify for any of these benefits a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband. The bill would eliminate ***4999** these support requirements for divorced wives, divorced widows, and surviving divorced mothers.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 100,000 additional women would become immediately eligible for benefits on the affective date, and $18 million in additional benefits would be paid in the first full year.

Waiver of duration-of-marriage requirement in case of remarriage

The duration-of-marriage requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild-- that is, the period of not less than nine months immediately prior to the day on which the worker died that is now required (except where death was accidental or in the line of duty in the uniformed service, in which case the period is three months)-- would be waived in cases where the worker and his spouse were previously married, divorced, and remarried, if they were married at the time of the worker's death and if the duration-of-marriage requirement would have been met at the time of the divorce had the worker died then.

Effective date.-- January 1972.

Disability insured status for individuals who are blind

Under present law, to be insured for disability insurance benefits a worker must be fully insured and meet a test of substantial recent covered work (generally 20 quarters of coverage in the period of 40 calendar quarters preceding disablement). The bill would eliminate the test of recent attachment to covered work for blind people; thus a blind person would be insured for disability benefits if he is fully insured-- that is, he has as many quarters of coverage as the number of calendar years that elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 300,000 additional people would become immediately eligible for benefits on the effective date, and $29 million in additional benefits would be paid in the first full year.

Wage credits for members of the uniformed services

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Present law provides for a social security noncontributory wage credit of up to $300, in addition to contributory credit for basic pay, for each calendar quarter of military service after 1967. Under the bill, the additional noncontributory wage credits would also be provided for service during the period January 1957 (when military service came under contributory social security coverage) through December 1967.

Effective date.-- January 1, 1972.

Number of people affected and dollar payments.-- 13,000 additional people would receive larger benefits on the effective date, and $39 million in additional benefits would be paid in the first full year.

Reduction in waiting period for disability benefits

The present 6-month period throughout which a person must be disabled before he can be paid disability benefits would be reduced by one month (to 5 months).

Effective date.-- January 1972.

***5000** Number of people affected and dollar payments.-- 950,000 people would receive increased benefits, and $105 million in additional benefits would be paid, in the first full year.

Disability insurance benefits applications filed after death

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) would be paid to the disabled workers' survivors if an application for benefits is filed within 3 months after the worker's death, on within 3 months after enactment of this provision.

Effective date.-- For deaths occurring after 1969.

Disability benefits affected by the receipt of workmen's compensation

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable if the combined payments exceed 80 percent of the worker's average current earnings before disablement. Average current earnings for this purpose can be computed on two different bases and the larger amount will be used. The bill adds a third alternative base, under which a worker's average current earnings can be based on the one year of his highest earnings in a period consisting of the year of disablement and the five preceding years.

Effective date.-- January 1972.

Number of people affected and dollar payments.-- 65,000 people would receive increased benefits on the effective date, and $4 million in additional benefits would be paid in the first full year.

Optional determination of self-employment earnings

Self-employed persons could elect to report for social security purposes two-thirds of their gross income from nonfarm self-employment, but not more than $1,600. (This optional method of reporting is similar to the option available under present law for farm self-employment.) A regularity of coverage requirement would have to be met and the option could be used only five times by any individual.

Effective date.-- Taxable years beginning after 1971.

Payments by an employer to the survivor or estate of a former employee

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Amounts earned by an employee which are paid after the year of his death to his survivors or his estate would be excluded from coverage. Under present law, such wages are covered and social security taxes must be paid on these wages but the wages cannot be used to determine eligibility for or the amount of social security benefits.

Effective date.-- January 1972.

Coverage of members of religious orders who are under a vow of poverty

Social security coverage would be made available to members of religious orders who have taken a vow of poverty, if the order makes an irrevocable election to cover these members as employees of the order.

Effective date.-- Upon enactment.

Self-employment income of certain individuals living temporarily outside the United States.

Under present law, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for approximately 17 months out of 18 consecutive months, must exclude the first $20,000 of his earned income in computing his taxable income ***5001** for social security and income tax purposes. The bill would provide that U.S. citizens who are self-employed outside the U.S. and who retain their residence in the United States would not exclude the first $20,000 of earned income for social security purposes and would compute their earnings from self-employment for social security purposes in the same way as those who are self-employed in the U.S.

Effective date.-- Taxable years beginning after 1971.

Penalty for furnishing false information to obtain a social security number

Provides criminal penalties when an individual furnishes false information in applying for a social security number with intent to deceive the Secretary as to his identity.

Trust fund expenditures for rehabilitation services

Provides an increase in the amount of social security trust fund monies that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits (as under present law) to 1 1/4 percent for fiscal year 1972 and to 1 1/2 percent for fiscal year 1973 and subsequent years.

Dollar payments.-- Additional payments for the cost of vocational rehabilitation services would amount to $17 million in the first full year.

Other OASDI amendments

Other changes relate to social security coverage of policemen and firemen in Idaho, public hospital employees in New Mexico, Federal Home Loan Bank employees, employees of the Government of Guam, and students employed by certain nonprofit organizations; retroactive payments for certain disabled people; social security benefits for a child entitled on the earnings record of more than one worker; benefits for certain dependent grandchildren; recomputation of benefits to survivors of a deceased worker who was entitled to both social security and railroad retirement benefits; authorization for the Managing Trustee of the social security trust funds to accept money gifts or bequests; and preserving the amount of a family's benefit when the worker's benefit is increased.

B. PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

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1. ELIGIBILITY AND PAYMENT FOR BENEFITS

Extending health insurance protection to disabled beneficiaries

Health insurance protection under title XVIII would be extended to persons entitled to monthly cash benefits under the social security and railroad retirement programs because they are disabled, after they have been entitled to disability benefits for at least two years.

Effective date.-- July 1972.

Number of people affected and dollar payments.-- About 1.5 million disabled social security and railroad beneficiaries would be eligible for both hospital benefits and physician coverage under medicare. About $1.85 billion in benefits would be paid on behalf of disabled beneficiaries in the first full year of the program.

***5002** Hospital insurance for the uninsured

People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Those who enroll would pay the full cost of the protection-- $31 a month at the beginning of the program rising as hospital costs rise. States and other organization, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

Effective date.-- January 1972.

Amount of supplementary medical insurance premium

The supplementary medical insurance premium will be determined as under present law for months through June 1972 ($5.30 through June 1971 and $5.60 from July 1971 through June 1972.) Thereafter, the Secretary of Health, Education, and Welfare would, as under present law, determine and promulgate for each year a monthly enrollee premium for both aged and disabled. However, the enrollee premiums would be increased only in the event of the enactment of legislation providing for a general benefit increase or in the event of an automatic general benefit increase. In any given year, the premium would rise by no more than the percentage by which cash benefits had been increased across the board in the interval since the premium was last increased. The premium amount paid by the beneficiary would never exceed one-half of total program costs.

Effective date.-- July 1972.

Change in supplementary medical insurance deductible

The Medicare part B deductible, currently $50 per year, would be increased to $60.

Effective date.-- January 1972.

Coinsurance under hospital insurance and the lifetime reserve

Coinsurance equal to one-eighth of the inpatient hospital deductible would be imposed for each day of inpatient hospital coverage during a benefit period beginning with the 31st day and continuing through the 60th day. This amount is now $7.50, but would increase as the inpatient hospital deductible increases (as hospital costs rise). (coinsurance for the 61st through 90th day would remain equal to one-fourth of the inpatient hospital deductible.) The lifetime reserve, under which the beneficiary pays one-half of the hospital deductible, would be increased from 60 days to 120 days.

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Effective date.-- Hospital stays beginning after 1971.

Automatic enrollment for supplementary medical insurance

People entitled to hospital insurance benefits would be automatically enrolled and covered for supplementary medical insurance benefits unless they indicate they do not want to be enrolled for such coverage.

Effective date.-- January 1972.

Incentives for comprehensive care under medicaid

Incentives would be created for States to contract with health maintenance organizations or similar facilities. At the same time, ***5003** disincentives would be provided to discourage prolonged stays in institutions. Specifically, there would be--

(1) an increase of 25 percent (up to maximum of 95 percent) in the Federal Medicaid matching percentage to States under contract with HMO'S or other comprehensive health to care facilities;

(2) a decrease in the Federal medical assistance percentage by one-third after the first 60 days of care in a general or TB hospital;

(3) a reduction in the Federal percentage by one-third after the first 60 days of care in a skilled nursing home unless the State establishes that it has an effective utilization review program;

(4) a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after 275 additional days of such care during an individual's lifetime except that the 90-day period may be extended for an additional 30 days if the State shows that the patient will benefit therapeutically from such an additional period of hospitalization; and

(5) authority for the Secretary to compute a reasonable cost differential for reimbursement between skilled nursing homes and intermediate care facilities.

Effective date.-- July 1, 1971, except that the reasonable cost differential provision would be effective January 1, 1972.

Cost sharing under medicaid

The Secretary of Health, Education, and Welfare would be able to require the payment of a premium, related to income, for those eligible as medically indigent (non-cash recipients) under a State medicaid program. In addition, states would be permitted to impose a nominal cost sharing with respect to cash recipients, but applying only to services not required to be provided under the State program. States could apply copayment provisions to the medically indigent which are not related to income.

Effective date.-- July 1, 1972.

Determination of payments under medicaid

Families eligible for cash assistance would have a deductible under medicaid equal to one-third of the family's earnings above $720 (after deducting he earnings of school children and any costs of required child care) less than the difference between the medicaid standard and the payment standard, if any, in that State. All States would be required to impose such a deductible. Any family with income below the State medicaid standard would be eligible for medicaid assistance.

Effective date.-- July 1, 1972.

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Relationship between medicare and Federal employees benefits

Effective with January 1, 1975, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that such plan or the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a contribution toward their health insurance premiums from either the Government or the individual plan.

Effective date.-- January 1975.

***5004** Medicare benefits for people living near United States border

Medicare beneficiaries living in border areas of the United States would be entitled to covered inpatient hospital care outside the United States if the hospital they use is closer to their residence than a comparable United States hospital and if it has been accredited by a hospital approval program with standards comparable to medicare standards. Coverage would also be extended in these cases to physicians' and ambulance services furnished in conjunction with covered foreign hospital care.

Effective date.-- January 1972.

2. IMPROVEMENTS IN OPERATING EFFECTIVENESS

Limitation on Federal participation for capital expenditures

Reimbursement amounts to providers of health services and health maintenance organizations under the medicare, medicaid, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to large capital expenditures which are inconsistent with State or local health facility plans. States would be required to establish procedures by which a facility or organization proposing a capital expenditure may appeal a decision by a planning agency.

Effective date-- July 1972 (or earlier if requested by a State).

Experiments and demonstration projects in prospective reimbursement and incentives for economy

The Secretary of Health, Education and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid, and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment of reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services); with areawide or community wide peer review, utilization review, and medical review mechanisms; and with performance incentives for intermediaries and carriers.

Effective date.-- Enactment.

Limits on costs recognized as reasonable

The Secretary of Health, Education, and Welfare would be given authority to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the costs of services in excess of those that are found necessary to the efficient delivery of a needed health services (except in the case of an admission by a physician who has a financial interest in the facility).

Effective date.-- July 1972.

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Limits on prevailing charge levels

Physicians' charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (a) that after December 31, 1970, medical charge levels recognized as prevailing may not be increased ***5005** beyond the 75th percentile of actual charges in a locality during the calendar year elapsing prior to the start of the fiscal year; (b) that for fiscal year 1973 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment, and services are widely available in a locality.

The existing Health Insurance Benefits Advisory Council is to conduct a study of the methods of reimbursement of physicians' fees under medicare and report to the Congress no later than July 1, 1972.

Effective date.-- (See provision.)

Limits on skilled nursing home and intermediate care facility costs

The average per diem costs for skilled nursing homes and intermediate care facilities countable for Federal financial participation under medicare would be limited to 105 percent of such costs for the same quarter of the preceding year. Increases resulting from higher labor costs due to minimum wage legislation would not count in computing the cost figure.

Effective date.-- January 1, 1972.

Payments to health maintenance organizations

Medicare beneficiaries could choose to have all covered care, except emergency services, provided by a health maintenance organization (a prepaid group health or other capitation plan). The Department of Health, Education, and Welfare would contract with such organizations and would reimburse them on a monthly per capita basis at a rate equivalent to 95 percent of the estimated per capita costs of medicare beneficiaries in the area who are not enrolled in such organizations. Profits accruing to the organization, beyond its retention rate for nonmedicare members, would be passed on to the medicare enrollees in the form of expanded benefits.

Effective date.-- January 1972.

Payments for services of teaching physicians

Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital had, in the 2-year period ending in 1967, and subsequently, customarily charged all patients and collected from at least 50 percent of patients fee-for-service basis. Medicare payments would also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

Effective date.-- Accounting periods beginning after June 30, 1971.

Advance approval of extended care and home health services under medicare

The Secretary of Health, Education, and Welfare would be authorized to establish minimum periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. The attending physician would certify to the condition and related need for the

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services. A similar provision would apply to post-hospital home health services.

Effective date.-- January 1972.

***5006** Termination of payments to suppliers of services who abuse the medicare or medicaid programs

The Secretary of Health, Education, and Welfare would be given authority to terminate payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

Effective date.-- Enactment.

Elimination of requirement that States have comprehensive medicaid programs

The existing requirement that States have comprehensive medicaid programs by 1977 would be repealed.

Effective date.-- Enactment.

Reductions in care and services under medicaid

The states would be permitted to eliminate or reduce the scope and extent of health services which are optional under the medicaid statute, e.g., outpatient drugs, eyeglasses and dental care. States would have to provide the same dollar amounts for their required health services.

Effective date.-- Enactment.

State determinations of reasonable hospital costs under medicaid

States would be allowed to develop methods and standards for reimbursing the reasonable cost of inpatient hospital services. Such costs could not exceed medicare rates.

Effective date.-- July 1, 1972, or earlier if a State plan so provides

Government payment no higher than charges

Payments for institutional services under the medicare, medicaid and maternal and child health programs could not be higher than the charges regularly made for these services.

Effective date.-- Accounting periods beginning after June 30, 1971.

Institutional planning under medicare

Health institutions under the medicare program would be required to have a written plan reflecting an operating budget and a capital expenditures budget.

Effective date.-- Sixth month following month of enactment.

Federal matching for automated medicaid systems

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Federal matching for the cost of designing, developing, and installing mechanized claims processing and information retrieval systems would be set at 90 percent and 75 percent for operation of such systems.

Effective date.-- July 1, 1971.

Prohibition of reassignments

Medicare (part B) and medicaid payments to anyone other than a patient, his physician, or other person providing the service, would be prohibited, unless the physician (or, in the case of medicaid, another type of practitioner) is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

Effective date.-- Enactment date for medicare; July 1, 1972 (or earlier at the option of the State) for medicaid.

***5007** Institutional utilization review under medicaid

The same utilization review committees now reviewing medicare cases in hospitals and nursing homes would be required to review medicaid cases in institutions utilized by medicare.

Stopping payment where hospital admission not necessary under medicare

If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

Effective date.-- Third month following the month of enactment.

Use of health agencies in medicaid

State medicaid programs would be required--

(1) To establish and implement plans, prepared by the State health agency, or other appropriate State medical agency, for the professional review of care provided to medicaid recipients, and

(2) Provide that the State medical agency which licenses health institutions shall perform that function for medicaid.

Effective date.-- July 1, 1972.

Medicaid and comprehensive health care programs

A state medicaid plan would not be out of compliance if it arranged for medicaid care through a comprehensive health plan in one or more areas which provided more services than are generally provided under the State’s medicaid plan.

Effective date.-- Enactment.

Program for determining qualifications for certain health care personnel

The Secretary of Health, Education, and Welfare would be required to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting specific formal criteria now included in medicare

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regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the medicare and medicaid programs.

Effective date.-- Enactment.

Penalty for fraudulent acts under medicare and medicaid

Present penalty provisions relating to the making of a false statement or representation of a material fact in any application for medicare payments would be broadened to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral, by providers of health care services. The penalty for such acts would be imprisonment up to one year, a fine of $10,000, or both. Similar penalty provisions would apply under medicaid.

Anyone who knowingly and willfully makes or induces the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or home health agency in order to secure medicare or medicaid certification of the facility or agency, would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than $2,000, or both.

Effective date.-- Enactment.

***5008** 3. MISCELLANEOUS AND TECHNICAL PROVISIONS

Physical therapy and other therapy services under medicare

Under medicare's supplementary medical insurance program, up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's plan would be included in covered charges. Hospitals and extended care facilities could provide therapy services under part B to inpatients who have exhausted their days of hospital insurance coverage. Where physical therapy and other ancillary services are furnished by a provider of services, or by others under arrangements with the provider, medicare reimbursement to the provider would in all cases be based on a reasonable salary payment for the services.

Effective date.-- January, 1972.

Coverage of supplies related to colostomies

Medicare coverage would be provided for colostomy bags and supplies directly related to colostomy care.

Effective date.-- Enactment.

Ptosis bars

Coverage would be provided under part B of medicare for ptosis bar devices required for the care of individuals suffering from paralysis or atrophy of the eyelid muscle.

Effective date.-- Enactment.

Intermediate care facilities under medicaid

The provisions for optional coverage of intermediate care facilities would be moved from title XI of the Act (where it applies, by reference to the cash assistance titles) to title XIX as an optional service. Services in a public institution for the mentally

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retarded could qualify if the primary purpose is to provide health or rehabilitation services and if the patient is receiving active treatment.

Effective date.-- January 1, 1972.

Coverage prior to application under medicaid

States would be required to provide medicaid coverage for care and services furnished in or after the third month prior to the application of an eligible person.

Effective date.-- July 1, 1972.

Certification of hospitalization for dental care

A dentist would be authorized to certify the necessity for hospitalization to protect the health of a medicare patient who is hospitalized for a noncovered dental procedure.

Effective date.-- Third month after month of enactment.

Grace period for paying medicare premium

Where there is good cause for a medicare beneficiary's failure to pay supplementary medical insurance premiums, an extended grace period of 90 days would be provided.

Effective date.-- Enactment.

***5009** Extension of time for filing medicare claims

The time limit for filing supplementary medical insurance claims would be extended where the medicare beneficiary's delay is due to administrative error.

Effective date.-- Enactment.

Waiver of enrollment period requirements where administrative error is involved

Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

Effective date.-- July 1966.

Three-year limitation on medicare enrollment dropped

Eligible beneficiaries would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program.

Effective date.-- Enactment.

Waiver of medicare overpayment

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Where incorrect medicare payments were made to a deceased beneficiary, the liability of survivors for repayment could be waived if the survivors were without fault in incurring the overpayment.

Effective date.-- Enactment.

Medicare fair hearings

Fair hearings, held by medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be conducted only where the amount in controversy is $100 or more.

Effective date.-- Enactment.

Collection of medicare premium by the railroad retirement board

Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his railroad retirement benefit in all cases. The Railroad Retirement Board is given authority to choose the carrier for part B benefits for its beneficiaries.

Effective date.-- Applicable to premiums becoming due after the fourth month following the month of enactment.

Prosthetic lenses furnished by optometrists

The definition of physician, for purposes of the medicare program, would be amended to include a licensed doctor of optometry, but only with respect to establishing the medical necessity or prosthetic lenses (which are already covered under the program).

Effective date.-- Enactment.

Social services requirement in extended care facilities

The present requirement for social services in extended care facilities under medicare would be removed.

Effective date.-- Enactment.

Refund of excess premiums

In the event of the death of a medicare beneficiary, any hospital or medical insurance premiums paid for any month after the month of his death will be refunded to his estate or to a survivor.

Effective date.-- Enactment.

***5010** Waiving of requirement for skilled nursing homes in rural areas

The requirement that skilled nursing homes under medicaid have at least one full-time registered nurse on the staff would be waived for up to one year at a time over a five-year period where the skilled nursing home is in a rural area and certain other conditions are met.

Effective date.-- Enactment.

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Exemption of Christian Scientist sanatoriums from certain requirements under medicaid

Christian Scientist sanatoriums under medicaid would be exempted from provisions in the bill which require certain health-related functions or conditions.

Effective date.-- Enactment.

Requirements for nursing home administrators

States would be permitted to provide under medicaid for a permanent waiver of a nursing home administrator who had been such an administrator for more than 3 years before the time the basic provision became effective (July 1970).

Effective date.-- Enactment.

Termination of Nursing Home Administration Advisory Council

The National Advisory Council on Nursing Home Administrations under medicaid would be terminated.

Effective date.-- Thirty days after enactment.

Increase in limit on payments to Puerto Rico for medicaid

The present limit of $20 million on the annual Federal payment for medicaid would be raised to $30 million. The present matching rate of 50 percent would be retained.

Effective date.-- Fiscal year 1972.

Provider reimbursement review board under medicare

Providers of services, under certain circumstances, would be permitted to appeal to a review board (established by the Secretary specifically to conduct such reviews) from a decision of the fiscal intermediary concerning the amount of program reimbursement, if the amount in controversy is at least $10,000.

Chiropractors' services

The Secretary of Health, Education, and Welfare would conduct a study of the desirability of covering chiropractors' services under medicare, utilizing the experiments and experience under the medicaid program. A report on the study, including the experience of other programs paying for chiropractors' services, would be submitted to the Congress within 2 years after enactment of the bill.

Effective date.-- Enactment.

Extension of title V to American Samoa and the Trust Territory of the Pacific

The crippled children and maternal and child health provisions of title V of the Act would be extended to American Samoa and the Trust Territory of the Pacific.

Effective date.-- Fiscal years beginning after June 30, 1971.

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FINANCING OASDHI

In order to finance the changes in the OASDHI program as amended by the bill, the limit on taxable earnings would be increased to $10,200 effective January 1972 and the following schedule of OASDI and HI tax rates would be provided

***5011** SOCIAL SECURITY TAX RATES AND MAXIMUM ANNUAL SOCIAL SECURITY TAXES FOR EMPLOYEES, EMPLOYERS, AND SELF-EMPLOYED

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

1ST-YEAR BENEFIT COSTS AND NUMBER OF PERSONS AFFECTED BY OLD-AGE, SURVIVORS, DISABILITY, AND MEDICARE PROVISIONS OF H.R. 1

(Amounts in millions; numbers of persons in thousands)

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

***5012** C. PROVISIONS RELATING TO ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

The existing Federal-State programs of aid to the aged, blind, and permanently and totally disabled would be repealed, effective July 1, 1972, and a new, totally Federal program would be effective on that date. The new national program is designed to provide financial assistance to needy people who have reached age 65 or are blind or disabled and would be established by a new Title XX of the Social Security Act. The program would be administered by the Social Security Administration through its present administrative framework and facilities.

The eligibility requirements and other legislative elements of the new program are as follows:

Eligibility for and amount of benefits

Individuals or couples could be eligible for assistance when their monthly income is less than the amount of the full monthly payment and their non-excluded resources are $1,500 or less.

Full monthly benefits for a single individual would be $130 for fiscal year 1973; $140 for fiscal year 1974, and $150 thereafter. Full monthly benefits for an individual with an eligible spouse would be $195 for fiscal year 1973, and $200 for fiscal year 1974 and thereafter. Benefits would not be paid for any full month the individual is outside the U.S.

The Secretary would establish the circumstances under which gross income from a trade or business, including farming, is large enough to preclude eligibility (net income notwithstanding). In addition, people who are in certain public institutions, or in hospitals or nursing homes getting medicaid funds, would be eligible for benefits of up to $25 a month. People who fail to apply for annuities, pensions, workmen’s compensation, and other such payments to which they may be entitled would not be eligible.

Definition of income

In determining an individual’s eligibility and the amount of his benefits, both his earned and unearned income would have to be taken into consideration. The definition of earned income would follow generally the definition of earnings used in applying the earnings limitation of the social security program. Unearned income would mean all other forms of income, among which are benefits from other public and private programs, prizes and awards, proceeds of life insurance not needed for expenses of last illness and burial (with a maximum of $1,500), gifts, support, inheritances, rents, dividends interest, and so forth. For people who live as members of another person’s household, the value of their room and board would be deemed to be 33 1/3 percent of the full monthly payment.

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The following items would be excluded from income:

1. Earnings of a student regularly attending school with reasonable limits.

2. Irregular earned income of an individual of $30 or less in a quarter and irregular unearned income of $60 or less in a quarter.

3. The first $85 of earnings per month and one-half above that for the blind and disabled (plus work expenses for the blind). The first $60 of earnings per month and one-third above that for the aged.

***5013** 4. The tuition part of scholarships and fellowships.

5. Home produce.

6. One-third of child-support payments from an absent parent.

7. Foster care payments for a child placed in the household by a child placement agency.

8. Assistance based on need received from certain public or private agencies.

9. Vocational rehabilitation allowances.

Exclusions from resources

Individuals or couples cannot be eligible for payments if they have resources in excess of $1,500. The following items would be excluded from resources:

1. The home to the extent that its value does not exceed a reasonable amount.

2. Household goods and personal effects not in excess of a reasonable amount.

3. Other property which is essential to the individual's support (within reasonable value limitations).

4. Life insurance policies (if their total face value is $1,500 or less).

Other insurance policies would be counted only to the extent of their cash surrender value.

The Secretary would prescribe periods of time and manners in which excess property must be disposed of in order that it not be included as resources.

Meaning of terms

An eligible individual must be a resident of the United States, Puerto Rico, the Virgin Islands, or Guam, be a citizen or an alien admitted for permanent residence, and be aged, blind, or disabled.

Aged individual: One 65 years of age or older.

Blind individual: An individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or equivalent impairment in the fields of vision.

Disabled individual: An individual who is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which is expected to last, or has lasted, for 12 months or can be expected to end in death. (This definition is now used for social security disability benefits.)

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Eligible spouse: An aged, blind, or disabled individual who is the husband or wife of an individual who is aged, blind, or disabled.

Child: An unmarried person who is not the head of a household and who is either under the age of 18, or under the age of 22 and attending school regularly.

Determination of marital relationship: Appropriate State law will apply except that, if two people were determined to be married for purposes of receiving social security cash benefits, they will be considered to be married, and two persons holding themselves out as married in the community in which they live would be considered married for purposes of this program.

Income and resources of a spouse living with an eligible individual may be taken into account in determining the benefit amount of the individual, whether or not the income and resources are available to him. Income and resources of a parent may count as income of a disabled or blind child.

***5014** Rehabilitation services

Disabled and blind beneficiaries would be referred to State agencies for vocational rehabilitation services. A beneficiary who refused without good cause any vocational rehabilitation services offered would not be eligible for benefits.

Optional State supplementation

A State which provides for a State supplement to the Federal payment could agree to have the Federal Government make the supplemental payments on behalf of the State. If a State agrees to have the Federal Government make its supplemental payments, the Federal Government would pay the full administrative costs of making such payments, but if it makes its own payments, the State would pay all of such costs.

States could, but would not be required to, cover under medicaid persons who are made newly eligible for cash benefits under the bill.

The Federal Government, in administering supplemental benefits on behalf of a State, would be required to recognize a duration of residency requirement if the State decided to impose such a requirement.

Payments and procedures

Benefits could be paid monthly, or otherwise, as determined by the Secretary of Health, Education, and Welfare. Benefits could be paid to an individual, an eligible spouse, partly to each, or to another interested party on behalf of the individual. The Secretary could determine ranges of incomes to which a single benefit amount may be applied.

Cash advances of up to $100 could be paid if an applicant appears to meet all the eligibility requirments and is faced with a financial emergency. Applicants apparently eligible for benefits on the basis of disability could be paid benefits for up to three months while their disability claim was in process.

The Secretary may arrange for adjustment and recovery in the event of overpayments or underpayments, and could waive overpayments to achieve equity and avoid penalizing people who were without fault.

People who are, or claim to be, eligible for benefits and who disagree with determinations of the Secretary, could obtain hearings if they request them within 30 days. Final determinations would be subject to judicial review in Federal district courts, but the Secretary’s decisions as to any fact would be conclusive and not subject to review by the courts.

The right of any person to any future benefit would not be transferable or assignable, and no money payable under the

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program would be subject to execution, levy, attachment, garnishment, or other legal process.

If an individual fails to report events and changes relevant to his eligibility without good cause, benefits which may be payable to the individual would be terminated or reduced.

The heads of other Federal agencies would be required to provide such information as the Secretary of HEW needs to determine eligibility for benefits.

***5015** Penalties for fraud

A penalty of up to $1,000 or up to one year imprisonment, or both, would be provided in case of fraud under the program.

Administration

The Secretary of HEW may make administrative and other arrangements as necessary to carry out the purposes of the program and the States could enter into agreements to administer the Federal benefits during a transitional period.

Evaluation and research

The Secretary of HEW would continually evaluate the program, including its effectiveness in achieving its goals and its impact on related programs. He could conduct research and contract for independent evaluations of the program. Up to $5 million a year would be appropriated to carry out the evaluation and research. Annual reports to the President and the Congress on the operation and administration of the program would be required.

D. PROVISIONS RELATING TO FAMILY PROGRAMS

The present program of aid to families with dependent children (AFDC) would be repealed effective July 1, 1972, and two new totally Federal programs would take effect on that day. The new programs would be adopted for a period of five years (through fiscal year 1977) in order to give Congress an opportunity to review their operation before continuing them in subsequent years. The new programs would be established by a new Title XXI in the Social Security Act. A description of the two new programs follows:

Families in which at least one person is employable would be enrolled in the Opportunities for Families program, administered by the Department of Labor. Families with no employable person would be enrolled in the Family Assistance Plan administered by the Department of Health, Education and Welfare.

1. OPPORTUNITIES FOR FAMILIES PROGRAM

Registration for employment and training

Every member of a family who is found to be available for work by the Secretary of Health, Education, and Welfare would be required to register for manpower services, training and employment.

An individual would be considered available for work unless such person--

(1) Is unable to work or be trained because of illness, incapacity, or age;

(2) Is a mother or other relative caring for a child under age 3 (age 6 until July 1974);

(3) Is the mother or other female caretaker of a child, if the father or another adult male relative is in the home and is

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registered.

(4) Is a child under the age of 16 (or a student up to age 22);

(5) Is needed in the home on a continuous basis because of illness or incapacity of another family member.

Nevertheless, any person (except one who is ill, incapacitated, or aged) who would be exempted from registering by the above provisions could voluntarily register.

***5016** Every person who registered (other than a volunteer) would be required to participate in manpower services or training and to accept available employment. An individual could not be required to accept employment however--

(1) If the position offered is vacant due to a strike, lockout, or other labor dispute;

(2) If the wages and other employment conditions are contrary to those prescribed by applicable Federal, State, or local law, or less favorable than those prevailing for similar work in the locality, or the wages are less than an hourly rate of 3/4 of the highest Federal minimum wage ($1.20 per hour under present law);

(3) If membership in a company union or non-membership in a bona fide union is required;

(4) If he has demonstrated the capacity to obtain work that would better enable him to achieve self-sufficiency, and such work is available.

Child care and other supportive services

The Secretary of Labor directly or by using child care projects under the jurisdiction of the Department of Health, Education, and Welfare, would provide for child care services for registrants who require them in order to accept or continue to participate in manpower services, training, employment, or vocational rehabilitation.

The Secretary of Labor would be authorized funds to provide child care by grant or contract. Families receiving such services might also be required to pay all or part of the costs involved.

Health, vocational rehabilitation, family planning, counseling, social, and other supportive services (including physical examinations and minor medical services) would also be made available by the Secretary of Labor to registrants as needed.

Operation of manpower services, training and employment programs

The Secretary of Labor would develop an employability plan designed to prepare registrants to be self-supporting. The Secretary would then provide the necessary services, training, counseling, testing, coaching, program orientation, job training, and followup services to assist the registrant in securing employment, retaining employment, and obtaining opportunities for advancement.

Provision would be made for voluntary relocation assistance to enable a registrant and his family to be self-supporting.

Public service employment programs would also be used to provide needed jobs. Public service projects would be related to the fields of health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facility and similar activities. The Secretary of Labor would establish these programs through grants or by contract with public or nonprofit agencies or organizations. The law would provide safeguards for workers on such jobs and wages could not be less than the higher of the prevailing or applicable minimum wage or the Federal minimum wage.

Federal participation in the costs of an individual's participation in a public service employment program would be 100 percent for the first year of his employment, 75 percent for the second year, and 50 percent for the third year.

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***5017** States and their subdivisions that receive Federal grants would be required to provide the Secretary of Labor with up-to-date listings of job vacancies. The Secretary would also agree with certain Federal agencies to establish annual or other goals for employment of members of families receiving assistance.

Allowances of individuals participating in training

An incentive allowance of $30 per month would be paid to each registrant who participates in manpower training (States would have the option of providing an additional allowance of up to $30). Necessary costs for transportation and similar expenses would also be paid.

Utilization of other programs

The Secretary of Labor would be required to integrate this program as needed with all other manpower training programs involving all sectors of the economy and all levels of government.

Rehabilitation services for incapacitated family members

Family members who are incapacitated would be referred to the state vocational rehabilitation service. A quarterly review of their incapacities would usually be made.

Each such incapacitated individual would be required to accept rehabilitation services that are made available to him, and an allowance of $30 would be paid him while he receives such services. (States would have the option of providing an additional allowance of up to $30.) Necessary costs for transportation and similar expenses would also be paid.

Evaluation and research; reports

The Secretary of Labor would be authorized to conduct research and demonstrations of the program and directed to make annual evaluation reports to the President and the Congress. An appropriation of $10,000,000 would be authorized for these purposes.

2. FAMILY ASSISTANCE PLAN

Payment of benefits

All eligible families with no member available for employment would be enrolled and paid benefits by the Secretary of Health, Education, and Welfare.

Rehabilitation services and child care for incapacitated family members

Family members who are unemployable because of incapacity would be referred to State vocational rehabilitation agencies for services. A quarterly review of their incapacities would usually be made. Such persons would be required to accept services made available, and would be paid a $30 per month incentive allowance plus transportation and other related costs. (States would have the option of providing an additional allowance of up to $30.)

Child care services would also be provided if needed to enable individuals to take vocational rehabilitation services.

Women of child-bearing age would be offered family planning services and the services would be provided if accepted.

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Evaluation and research; reports

The Secretary of Health, Education, and Welfare would be authorized to conduct research and demonstrations of the family assistance ***5018** plan and directed to make annual evaluation reports to the President and the Congress. An appropriation of $10,000,000 would be authorized for these purposes.

3. DETERMINATION OF BENEFITS

Uniform determinations

Both Secretaries would be required to apply the same interpretations and applications of fact to arrive at uniform determinations of eligibility and assistance payment amounts under the two family programs.

Eligibility for and amount of benefits

Family benefits would be computed at the rate of $800 per year for the first two members, $400 for the next three members, $300 for the next two members and $200 for the next member. This would provide $2,400 for a family of four, and the maximum amount which any family could receive would be $3,600. A family would not be eligible if it had countable resources in excess of $1,500 or less.

If any member of the family fails to register, take required employment or training, or accept vocational rehabilitation services, the family benefits would be reduced by $800 per year.

Benefits would be determined on the basis of the family's income for the current quarter and the three preceding quarters.

After a family has been paid benefits for 24 consecutive months, a new application would be required which would be processed as if it were an initial application.

The Secretary would establish the circumstances under which gross income from a trade or business, including farming, is large enough to preclude eligibility (net income notwithstanding).

Families would have to apply for all other benefits available to them in order to be eligible.

A family headed by a regular, full-time college student would not be eligible.

Definition of income

Earned income would follow generally the definition of earnings used in applying the earnings limitation of the social security program. Unearned income means all other forms of income among which are benefits from other public and private programs, prizes and awards, proceeds of life insurance not needed for last illness and burial (with a maximum of $1,500), gifts, support inheritances, grants, dividends, interests and so forth.

All income except that excluded would be used to reduce the benefits otherwise payable.

The following items would be excluded from the income of a family:

1. Earnings of a student regularly attending school, with limits set by the Secretary.

2. Irregular earned income of an individual of $30 or less in a quarter and irregular unearned income of $60 or less in a quarter.

3. Earned income used to pay the cost of child care under a schedule prescribed by the Secretary.

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4. The first $720 per year of other earned income plus one-third of the remainder.

5. Assistance based on need received from public or private agencies, except veterans' pensions.

***5019** 6. Training allowances

7. The tuition part of scholarships and fellowships.

8. Home produce.

9. One third of child support and alimony.

10. Foster care payments for a child placed in the family by a child placement agency.

The total of the exclusions under (1), (2), and (3) above could not exceed $2,000 for a family of four rising by $200 for each additional member to an overall maximum of $3,000.

Exclusions from resources

A family cannot be eligible for payments if it has resources in excess of $1,500. In determining what is included in the $1,500 amount, the following items are excluded:

1. The home to the extent that its value does not exceed a reasonable amount.

2. Household goods and personal effects not in excess of a reasonable amount.

3. Other property which is essential to the family's self-support.

An insurance policy would be counted only to the extent of its cash surrender value except that if the total face value of all such policies with respect to an individual is $1,500 or less, no cash surrender value would be counted.

The Secretary would prescribe periods of time, and manners in which, property must be disposed of in order that it would not be included as resources.

Meaning of family and child

A family would be defined as two or more related people living together in the United States where at least one of the members is a citizen or a lawfully admitted alien and where at least one of them is a child dependent on someone else in the family.

No family will be eligible if the head of the household is an undergraduate or graduate student regularly attending a college or university full time. Benefits would not be payable to an individual for any month in which he is outside the United States.

The term 'child' means an unmarried person who is not the head of the household, and who is either under the age of 18 or under the age of 22 if attending school regularly.

Appropriate State law would be used in determining relationships.

The income and resources of an adult (other than a parent or the spouse of a parent) living with the family but not contributing to the family would be disregarded and the adult will not be considered a family member.

If an individual takes benefits under adult assistance, he could not be eligible for family benefits.

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Optional State supplementation

If a State decided to supplement the basic Federal payment, it would be required to provide benefit amounts that do not undermine the earnings disregard provision. A State could agree to have the Federal Government make the supplementary payments on behalf of the State. If a State agrees to have the Federal Government make its supplemental payments, the Federal Government would pay the full administrative costs of making such payments, but if it makes its own payments the State would pay all of such costs.

***5020** States could, but would not be required to, cover under medicaid persons who are made newly eligible for cash benefits under the bill.

The Federal Government, in administering supplemental benefits on behalf of a State, would be required to recognize a duration of residency requirement if the State decided to impose such a requirement.

4. PROCEDURAL AND GENERAL PROVISIONS

Payments and procedures

The Secretary would be permitted to pay the benefits at such times as best carry out the purposes of the title and could make payments to a person other than a member of the family or to an agency where he finds inability to manage funds. The Secretary's decision would be subject to hearing and review.

The family benefits could not be paid to an individual who failed to register or take work, training or vocational rehabilitation.

Cash advances of $100 or less could be paid if a family appears to meet all the eligibility requirements and is faced with a financial emergency.

The Secretary may arrange for adjustment and recovery in the event of overpayments or underpayments, with a view toward equity and avoiding penalizing people who were without fault.

People who are, or claim to be, eligible for assistance payments, and who disagree with determinations of the Secretary, could obtain hearings if they request them within 30 days. Final determinations would be subject to judicial review in Federal district courts, but the Secretary's decisions as to any fact would be conclusive and not subject to review by the courts. The Secretary would also be given authority to appoint qualified people to serve as hearing examiners without their having to meet the specific standards prescribed under the Administrative Procedure Act for hearing examiners.

The right of any person to any future benefit would not be transferable or assignable, and no money payable under this title would be subject to execution, levy, attachment, garnishment, or other legal process.

In addition, the Secretary would establish necessary rules and regulations dealing with proofs and evidence, and the method of taking and furnishing the same, in order to establish the right to benefits.

Each family would be required to submit a report of income within 30 days after the end of a quarter and benefits would be stopped until the report was filed. If a family failed, without good cause, to report income or changes in circumstances as required by the Secretary, it would be subject to a penalty of $25 the first time, $50 the second time and $100 for later times.

The head of any Federal agency would be required to provide such information as the Secretary of HEW needs to determine eligibility for benefits under this title.

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Penalties for fraud

A penalty of $1,000 or 1 year imprisonment, or both, would be provided in the case of fraud under the program.

Administration

Both the Secretary of Health, Education, and Welfare and the Secretary of Labor could perform their functions directly, through ***5021** other Federal agencies, or by contract. An additional Assistant Secretary is authorized in the Department of Labor to head up the new program in that Department.

Child care

The Secretaries of Labor and Health, Education, and Welfare are each given the authority and responsibility for arranging day care for their respective recipients under the Opportunities for Families program and the Family Assistance Plan who need such day care in order to participate in training, employment, or vocational rehabilitation. Where such care can be obtained in facilities developed by the Secretary of Health, Education, and Welfare, these would be utilized.

Insofar as possible, arrangements would be made for after school care with local educational agencies. All day care would be subject to standards developed by the Secretary of Health, Education, and Welfare, with the concurrence of the Secretary of Labor. Both Secretaries would have authority to make grants and contracts for payment of up to 100 percent of the cost of care. The Secretary of Health, Education, and Welfare would have total responsibility for construction of facilities. $700 million would be authorized for the provision of child care services in the first fiscal year, and such sums as Congress may appropriate in subsequent years. In addition, $50 million would be authorized for construction and renovation of child care facilities for each fiscal year.

Obligations of parents

A deserting parent would be obligated to the United States for the amount of any Federal payments made to his family less any amount that he actually contributes by court order or otherwise to the family.

Any parent of a child receiving benefits who travels in interstate commerce to avoid supporting his child would be guilty of a misdemeanor and subject to a fine of $1,000, imprisonment for 1 year, or both.

The Secretary would report to appropriate officials cases of child neglect or abuse which came to his attention while administering the program.

Local committees to evaluate program

Local advisory committees would be set up throughout the country, with a minimum of one in each State, which would evaluate and report on the effectiveness of the elements of the program designed to help people become self-supporting. Each committee would be composed of representatives from labor, business, and the public, as well as public officials not directly involved in the administration of the programs.

E. OTHER RELATED ASSISTANCE PROVISIONS

ADOPTION AND FOSTER CARE SERVICES UNDER CHILD WELFARE

Authorizations of $150 million for fiscal year 1972 and higher amounts for subsequent years would be provided for payments to the States to support foster care and adoption services.

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***5022** PROVISIONS RELATED TO NEW ASSISTANCE PROGRAMS

Effective date for adult assistance and family programs

Major changes made in the assistance programs would be effective July 1, 1972. The child care provisions would become effective upon enactment of the bill. The amendments which provide benefits to families where the father is in the family and working full-time, would become effective January 1, 1973.

Prohibition against participation in food stamp program by recipients of payments under family and adult assistance programs

The bill would amend the Food Stamp Act of 1964 by providing that families and adults eligible for benefits under the assistance programs in this bill would be excluded from participation in the food stamp program.

Special provisions for Puerto Rico, the Virgin Islands, and Guam

There would be special provisions for Puerto Rico, the Virgin Islands, and Guam. The amounts used in the family assistance plan and the aid to the aged, blind, and disabled (other than the $720 amount of annual earnings to be disregarded and the $30 per month incentive allowances) would be adjusted by the ratio of the per capita income of each of these jurisdictions to the per capita income of the lowest of the 50 states.

Determination of medicaid eligibility

The Secretary would be able to enter into agreements with States under which the Secretary would determine eligibility for medicaid both for those eligible for Federal payments and the medically needy in cases where the State covered the medically needy. The State would pay half of the Secretary's additional administrative costs arising from carrying out the agreement.

Effective date.-- July 1, 1972.

Transitional administration of public assistance

The Secretaries of Labor and of Health, Education, and Welfare could enter into agreements with States under which a State would administer the Federal assistance program for a period of up to one year from the beginning of the program.

Limitations on increases in State welfare expenditures

States would be guaranteed that, if they make payments supplementary to the Federal adult or family programs, it would cost them no more to do so than the amount of their total expenditures for cash public assistance payments during calendar year 1971, to the extent that the Federal payments and the State supplementary payments to recipients do not exceed the payment levels in effect under the public assistance programs in the State for January 1971. The value of food stamps would be taken into account in computing whether the guarantee would go into effect if the State pays in cash the value of food stamps. Most States would save money under the provisions of the bill; this provision would guarantee that no State would lose money.

Limitation on Federal expenditures for social services

The Federal Government would continue to provide 75 percent matching funds to the States for child care and family planning services ***5023** on an open-end appropriation basis. Federal matching for other specified social services would be limited to the amounts appropriated by the Congress. This provision would be effective on July 1, 1972.

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PUBLIC ASSISTANCE AMENDMENTS EFFECTIVE IMMEDIATELY

Additional remedies for State noncompliance with provisions of assistance titles

The Secretary would be able to require States to make payments to people who did not receive all money due them because the State failed to comply with a Federal requirement.

The Secretary could require a State which is in noncompliance with a Federal requirement to set up a timetable and method for assuring compliance, or could request the Attorney General to bring suit to enforce the Federal requirements.

Effective date.-- Enactment.

Statewideness not required for services

A State would be permitted to furnish social services in one area of a State without being required to furnish such services in all geographic areas of the State.

Effective date.-- Enactment.

Optional modification in disregarding income under AFDC

States would be permitted, between enactment and July 1, 1972, to modify their present AFDC programs so as to substitute the earnings disregard provisions in the family assistance provisions (cost of child care, plus $720, plus one-third of the remainder) for provisions of present law (the first $30 and one-third of the remainder after which actual work expenses are deducted).

A State could also apply the maximum dollar limits in the family programs on child care and student earnings ($2,000 for a family of four rising to $3,000 for a family of nine or more) to its present AFDC program.

Effective date.-- Enactment.

Individual programs for family services not required

States would no longer be required to prepare a separate plan of services for each individual who is eligible for AFDC.

Effective date.-- July 1, 1972, or earlier if the State so chooses.

Enforcement of support orders

States would be required to secure support for a spouse of a parent from the other parent (of children receiving assistance payments) where he has deserted or abandoned his spouse, utilizing reciprocal arrangements with other States to obtain or enforce court orders for support.

Effective date.-- July 1, 1972, or earlier, if the State plan so provides.

Separation of social services and cash assistance payments

Each State would be required to submit a proposal to the Secretary by January 1, 1972 providing for the administrative separation of handling eligibility for cash payments and the provision of social services by July 1, 1972.

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***5024** Increase in Federal matching to States for costs of establishing paternity and collecting child support payments

Federal matching would be increased from 50 percent to 75 percent for State costs incurred in establishing the paternity of AFDC children and locating and collecting support from their absent parents.

Effective date.-- Enactment.

Vendor payments for special needs

States would be permitted to provide for non-recurring items of special need by means of vendor payments.

Effective date.-- Enactment.

Increase in Federal matching-WIN program

Effective July 1, 1971, the Federal matching under the WIN program would be increased from 80 to 90 percent. This provision expires June 30, 1972.

F. PROVISIONS FOR TAX CHANGES (OTHER THAN PAYROLL TAXES)

Child Care Deduction

Under present law, a child care deduction of $600 per child, but not more than $900, is available for child care expenses in certain cases. Generally, this amount is available in the case of such expenses incurred by a widow or widower or certain other married couples with an incapacitated spouse and also in the case of married couples with incomes of not over $6000.

The new provision retains the basic child care provision of present law but increases from $6,000 to $12,000 the income a married couple may have and still be eligible for this deduction. In addition, the amount of child care expenses which may be deducted is increased from $600 for the first child to $750, and to $1,125 for two children, and to $1,500 for three or more children. These changes are effective with respect to taxable years beginning on or after January 1, 1972.

Retirement Income Credit

Under present law, a retirement income credit of up to $1,524 multiplied by 15 percent ($229) is allowed for single persons age 65 or over having ‘retirement income‘-- that is, income from pensions, dividends, interest, rents or other passive income sources. However, this credit is available only if the individual had ten prior years of earned income above $600. The income eligible for this credit is reduced, however, by social security, railroad retirement or other tax-exempt pension income. It is also reduced by 50 percent of earnings over $1,200 and 100 percent of earnings over $1,700. (This earnings limitation, however, does not apply to those age 72 and over.) For married couples a credit equal to one and one-half times the credit referred to above is generally available under present law. However, in some cases where both can qualify for the credit a credit of up to twice that referred to above is available.

In addition, under present law, the retirement income credit determined substantially as indicated above is available for retirement income received from governmental units where the individual is under age 65, except that the credit is reduced on a dollar-for-dollar basis for earnings above $900 (between age 62 and 65 the earnings test described above applies).

***5025** The committee has adopted a substitute retirement income credit which is both more liberal and also will be easier to compute on the return form. This credit for a single person will be based upon $2,500 instead of $1,524. It will not be necessary for the individual involved to have ‘retirement income‘ as he is required to have under present law or 10 years of prior earnings of $600 or more. However, as under present law, the $2,500 will be reduced for social security, railroad retirement and other tax-exempt pension income. Also, as under present law, it will be reduced for earned income above a

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specified level (if the individual is under age 72). However, the amount will only be reduced for 50 percent of earnings above $2,000 instead of 50 percent of earnings above $1,200 plus 100 percent of earnings above $1,700.

As under the present law, the amount derived in this manner is multiplied by 15 percent in order to obtain the credit (the new figure gives a maximum credit of $375).

For a married couple, both over age 65, the retirement income credit is to be based upon $3,750 instead of the $2,500 applicable to a single person. Otherwise, the credit is to be computed in the same manner indicated above except on the basis of the combined experience of the husband and wife.

For those below age 65 receiving Government pension income the $2,500 also becomes applicable but, as under present law, only with respect to Government pension income. The earnings test for these persons is raised from $900 to $1,000 if under age 62 but for those above that age, the $2,000 earnings test applies.

III. GENERAL DISCUSSION

A. PROVISIONS RELATING TO THE CASH BENEFITS PROGRAM

5-percent benefit increase

Your committee's bill would provide a general 5-percent increase in social security benefits payable for June 1972.

In considering the need for a general benefit increase your committee recognizes that legislation enacted in March of this year provided a 10-percent general benefit increase effective for January 1971. However, your committee believes that economic changes over the next year will probably necessitate a further increase, While your committee has no intention of forecasting what economic changes will occur over the next year or so, it seems practical to expect the general trends of the past to continue. Accordingly, your committee is recommending that social security benefits generally be increased by 5 percent, effective with the benefits payable for June 1972. In recommending that the increase be effective for June 1972, the committee was guided by a number of practical considerations. In particular, an increase effective in that month would be payable in July and would coincide with other changes being recommended by your committee; the new Federal assistance program for needy families, the aged, the blind, and the disabled will go into effect at that time and it seems desirable to coordinate the effect of the future benefit increase on these program.

Under present law, monthly benefits for workers who retire at age 65 in June 1972 would range from $70.40 to $216.10; under the bill these ***5026** amounts would range from $74.00 to $227.00. Additional illustrations of the effect of the benefit increase are shown in the table below. The table also reflects the effect of increasing the contribution and benefit base to $10,200 effective January 1, 1972.

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER PRESENT LAW AND UNDER H.R. 1

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Some 26.9 million beneficiaries-- persons receiving regular cash benefits under present law-- on the rolls in July 1972 would have their benefits increased under this provision. An estimated $2,048 million in additional benefits would be paid in the first full year.

The bill would also increase by 5 percent the special cash payments that are made under present law to certain people age 72 and who are not insured for regular cash benefits under the social security program. The payments would be increased from $48.30 to $50.80 for an individual and from $72.50 to $76.20 for a couple, effective for June 1972. As a result, about 16,000 people who do not get the special payments would qualify for some payments, and about 0.5 million people would qualify for higher payments under this provision. An estimated $25 million in additional payments would be paid out in the first full year; about $22 million of this amount would be borne by general revenues.

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Automatic increases in benefits, the tax base, and the earnings test

Your committee has given careful consideration to several proposals to provide automatic cost-of-living increases in social security benefits and has concluded that authority should be provided for cost-of-living increases if future price rises should cause serious erosion in the purchasing power of social security benefits. Recognizing, however, that Congress has legislated eight benefit increases since monthly benefits were first paid in January 1940 (in addition to the proposed 5-percent increase in this bill) and that the cumulative effect of these benefit increases greatly exceeds the rise in the cost of living over the same period, your committee recommends a provision under which automatic benefit increases would go into effect only after Congress had an opportunity to consider whether any other benefit increase would be more appropriate in the light of prevailing economic conditions.

***5027** The provisions of the committee amendment have been drawn with a view to preserving the role of Congress in determining when and in what amounts social security benefits should be raised while at the same time assuring that the purchasing power of social security benefits will not be seriously eroded by inflationary changes in the economy.

Under the provisions of the amended bill reported by your committee, benefits could be increased automatically each January whenever the cost of living rises three percent or more between specified base periods. However, an automatic benefit increase would not go into effect if in the year preceding the January for which it would otherwise become effective, a general benefit increase (other than an automatic benefit increase) had become effective or had been enacted.

Each year the Secretary of Health, Education, and Welfare would compare the monthly average of the Consumer Price Index for the second calendar quarter with the monthly average of the Index for the most recent second calendar quarter which was used to compute an automatic benefit increase or, if later, the calendar quarter in which a legislated benefit increase became effective. If the rise in the Consumer Price Index was 3 percent or more, the Secretary would promulgate (not later than November 1) the benefit increase effective for the following January. The benefit increase would be equal to the percentage rise in the Consumer Price Index rounded to the nearest 0.1 of one percent.

In order to assure that the appropriate Congressional legislative committees are kept informed as to the likelihood of imminent action being taken under the automatic increase provisions, the bill would require the Secretary of Health, Education, and Welfare, (1) to notify the Congress whereever there is a 2.5 percent rise in the cost of living since the latest base period, and (2) to notify Congress, prior to promulgating any automatic increase (not later than the middle of August), whenever a rise in prices would cause an automatic benefit increase to go into effect the following January. Along with this later notification, the Secretary would be required to indicate the amount of the increase, his estimate of the extent to which the cost of the benefit increase could be met through the automatic increase in the tax base which would be provided (as discussed below), the estimated increase in the base, the actuarial estimates of the effect of the increase and the actuarial methodology and assumptions used in making these estimates. Following these notifications, Congress would have an opportunity to determine whether the automatic increase or some other increase should go into effect.

In order to provide additional financing to help meet the increased costs of automatic cost-of-living increases in benefits, the committee amendment provides for automatic increases in the tax and benefit base which would go into effect only when an automatic benefit increase became effective. The base would be automatically increased in proportion to the increase in the level of average covered wages in the first calendar quarter of the year in which the computation is made over the level of average covered wages in the first calendar quarter of the later of; the most recent year in which an increase in the tax and benefit base was enacted, or the most recent year in which a determination was made to automatically adjust the contribution and benefit base.

The retirement test exempt amount-- the amount a beneficiary under age 72 can earn in a year and still receive all his benefits-- would ***5028** also be automatically increased the same way as the contribution and benefit base; that is, in proportion to increases in the level of average covered wages between first calendar quarters. Like the base increases, the automatic retirement test increases would occur only when there is an automatic increase in benefits. This provision would provide retirement test changes current with increases in earnings and would avoid extended lags between such increases and changes in the test.

In order to provide increased benefits for people who have worked regularly for many years in covered jobs at low earnings, your committee is recommending a special minimum benefit equal to $5 multiplied by the number of years of coverage in

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individual has under the program up to a maximum of 30 years. This would be an alternative to the provisions of present law and if the regular benefit amount is or becomes larger than the special minimum, the regular benefit would be paid.

Thus, the amendment would increase the minimum benefit payable to people with 15 or more years of coverage. A person with 15 years of coverage, for example, would get at least $75; a person with 20 years of coverage, at least $100; a person with 25 years of coverage, at least $125; and a person with 30 or more years of coverage, at least $150 (the maximum payable under the provision).

Because 35 years have elapsed since the social security program began, a worker who has earnings in every year after 1937 could get the highest special minimum benefit of $150 in 1972. For a worker with earnings after 1950 only, the highest special minimum benefit payable in 1972 would be $105; the $150 benefit would not be payable to such a worker until 1981. Benefits determined under the special minimum would not be increased under the automatic cost-of-living benefit increase provisions.

Under the bill, for purposes of determining the amount of an individual's special minimum benefit, the number of years of coverage for the period 1937-1950 would be determined on a presumptive basis by dividing the total wages credited to an individual for years after 1936 and prior to 1951 by $900, disregarding any fraction and limiting the total to 14. (This method is a practical way to determine years of coverage for the period 1937-1950 because the records of the Social Security Administration available for machine use indicate total earnings for the entire 14-year period but not earnings for individual years.) The number of years of coverage after 1950 would be determined on an individual-year basis; each year for which the individual is credited with wages and self-employment income of at least 25 percent of the contribution and benefit base for that year would be a year of coverage. The amount used for determining years of coverage before 1951 has been set at $900, rather than 25 percent of the $2000 base ($750) in effect before 1951 as an offset to the generous treatment resulting from the use of the presumptive basis.

Some 300,000 people would get increased benefits on the effective date and $30 million in additional benefits would be paid in the first full year.

Increase in widow's and widower's insurance benefits

A factor which must be taken into account in considering whether the levels of social security benefits are adequate at any given time is ***5029** the relationship of survivors' benefits to the worker's retirement benefit. In this connection your committee examined the benefits paid to older widows and found that their benefits are not adequate.

When social security benefits were first provided for widows by the **Social Security Amendments** of 1939 they were set at 75 percent of the worker's retirement benefit. This amount was based on the idea that a widow should receive one-half of the combined benefit which would have been paid to her and her husband had both been entitled to benefits. Later, this amount was increased by 10 percent, to 82.5 percent, where it has remained up to the present time.

It is your committee's opinion that the reasons for setting widow's benefits at their present level are no longer valid and that in the light of present conditions there is no reason for paying aged widows less than the amount which would be paid to their husbands as retirement benefits. Currently, the average benefit for an aged widow is about $114 a month, while the average benefit for a retired worker is about $141 a month. In addition, surveys of social security beneficiaries have shown that, on the average, women getting aged widows' benefits have less income other than from social security than most other beneficiaries.

The committee bill would provide benefits for a widow equal to the benefit her deceased husband would have received if he were still living. Under the bill, a widow whose benefits start at age 65, or after, would receive either 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement at age 65) or, if his benefits began before age 65, an amount equal to the reduced benefit he would have been receiving if he were alive. In no case, however, would a widow receive a smaller benefit than she would be entitled to under present law.

Under the committee's bill the benefit for a widow (or widower) who comes on the rolls between 60 and 65 would be reduced (in a way similar to the way in which widow's benefits are reduced under present law when they begin between ages

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60 and 62) to take account of the longer period over which the benefit would be paid. For example, the benefit amount for a widow becoming entitled to a widow's benefit at age 63 would be 88.6 percent of her husband's benefit; for a widow becoming entitled at age 64, the amount would be equal to 94.3 percent of her husband's benefit. (Because of the necessity of gearing in the widow's benefits between the ages of 62 and 65 with the higher amount provided under present law for a widow at age 62, as compared with the amount provided for a worker age 62, the reduction for widows and widowers who receive benefits beginning before age 65 is slightly different than the reduction for workers between ages 62 and 65.)

Under the bill, the benefit amount for January 1972 for a widow (or widower) who came on the benefit rolls before 1972 would be redetermined as though the new provisions had been in effect when she came on the rolls. Thus, the widow already on the rolls who started getting benefits before she reached age 65 would have the 100-percent widow's benefit reduced to take account of the longer period for which she would be paid benefits. In order to permit the use of machine records in determining the benefit amount aht the deceased spouse would have been receiving if he were alive, the Social Security Administration will assume that his benefits were based on the same average ***5030** monthly earnings which determine the primary insurance amount on which the widow's (or widower's) benefits are based for January 1972.

Under the bill, as under present law, the benefit for a widow who is age 62 or older when she starts getting benefits and who is the only survivor getting benefits would be not less than $70.40, the minimum benefit now payable to a retired worker at age 65. The benefit for a widow who starts getting benefits before 62 and who is the only survivor getting benefits would be no less than the minimum worker's benefit reduced to take account of months before age 62 for which the benefit is paid.

The changes made with respect to widows would also apply to eligible dependent widowers.

ILLUSTRATIVE MONTHLY BENEFITS FOR WIDOWS AND WIDOWERS WHO BECOME ENTITLED AT OR AFTER AGE 65 UNDER PRESENT LAW AND UNDER H.R. 1 [2]

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

The increase in benefits for widows and dependent widowers would be effective for January 1972.

Some 3.4 million widows and widowers on the rolls at the end of January 1972 would receive higher benefits under this provision, and $764 million in additional benefit payments would be made in the first full year.

Increased benefits for those who delay retirement beyond age 65

Under present law, a person who continues working and delays retirement beyond age 65 pays contributions on his earnings, foregoes benefits, and may get no more in monthly benefits when he finally retires than he would have been paid had he retired at age 65. In some cases, however (where average monthly earnings increase due to work after age 65) monthly benefits can be greater than the benefits that would have been paid at 65, since earnings in years after 65 can be substituted for lower earnings in prior years in figuring the average earnings on which benefits are based.

Your committee's bill would provide increased benefits to people who do not get benefits because they are working between ages 65 and 72.

For each month of work beginning with the month of attainment of age 65 and ending with the month before a worker reaches age 72, ***5031** his benefit would be increased by one-twelfth of 1 percent for each month for which his benefit was not payable.

As under present law, benefits would be recomputed for any year after age 65 in which a person has earnings. Benefits reflecting the increase (after taking into account the months in which a worker was insured but for which he got no benefits) would be payable beginning the following January.

For example, a man who retires at age 65 in January 1972 with earnings of $4000 in each year of his computation period could get a monthly benefit of $180.10 for June 1972. If he worked for 12 months in 1972, earning $6,000, his average monthly earnings would be increased from $444 to $343, and his benefit before application of the delayed-retirement credit

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provision would be increased to $184.80. This amount would then be increased by 1 percent to $186.70.

The delayed-retirement increment-- unlike the increase resulting from the increase in average monthly earnings-- would apply to the old-age insurance benefit only, and would not affect benefits of dependents or survivors.

The provisions would be applicable prospectively only for computations and recomputations after 1971. As a result, 400,000 people would get higher benefits, and $11 million in additional payments would be paid, in the first full year.

Age-62 computation point for men

Under present law, retirement benefits for men are figured differently, and less advantageously, than benefits are for women. For a man the period for determining the number of years of earnings that are used in figuring the average monthly earnings on which his benefit is based ends with the beginning of the year in which he reaches age 65. For a woman the period ends with the beginning of the year in which she reaches age 62. Thus, 3 more years are used in computing benefits for a man than are used for a woman of the same age. This difference in the treatment of men and women can result in significantly lower benefits being paid to a retired man than are paid to a retired woman with the same earnings.

For example, take the case of a man and a woman each of whom reaches age 65 and retires in 1971, and each of whom has maximum creditable earnings under the program in each year up to 1971. The woman's benefit would be $220.40 a month under present law, while the man's benefit would be only $213.10 a month. If both workers retire at age 62 in 1971, the woman's benefit would be $170.50 a month wile the man's benefit would be only $163.60 a month.

The bill would change the way in which a man's retirement benefit is figured to make the computation the same as the computation of a woman's benefit.

The provision would apply only to those who become entitled to benefits in the future; a 3-year transition period would be provided. The number of years used in computing benefits for men would be reduced in three steps; men reaching age 62 in 1972 would have years up to age 64 taken into account; men who reach age 62 in 1973 would have years up to age 63 taken into account; and men who reach age 62 in 1974 or later would have years up to age 62 taken into account.

The bill would also provide a three-step reduction in the number of quarters of coverage needed for insured status for men, making ***5032** the ending point age 62 for both men and women, and thus would allow men to become fully insured on the basis covered employment than is now required. The first step in this reduction would be effective for January 1972, with subsequent reductions becoming effective in 1973 and 1974, as with the benefit computation.

Additional dropout years

Under the present law, social security benefits for a worker and his family are generally based on the worker's average monthly earnings in covered work over a period equivalent to the time elapsing after 1950 and up to the year in which he reaches age 65 (62 for a woman), becomes disabled, or dies. (Another provision of the bill would change the ending point for men to age 62.) Up to 5 years in which earnings are lowest are excluded from the computation of the worker's average monthly earnings. This five-year dropout provision helps to lessen the effect that periods of unemployment, illness, and low earnings can have on benefit amounts.

Your committee's bill would provide an additional dropout year for each 15 years of coverage that a worker has. (A year of coverage would be defined as it would be under the new special minimum provision.) The effect of the additional dropout would be to give additional protection against the lowering of average monthly earnings of long-term contributors to the program. In addition, the higher benefits that will result from increases in the upper limit on earnings counted under the program will be more quickly available for these long-term contributors because fewer years when lower ceilings were in effect would be included in figuring average monthly earnings.

The provision would be effective for workers who attain age 62 after 1971 and become entitled to old age or disability benefits or die after 1971 and to workers who attain age 62 after 1971 who were entitled to disability benefits for December

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1971. About $17 million in additional benefits would be paid in the first full year.

Election to receive actuarially reduced benefits

Under present law, a married person who has worked and is eligible for both an old-age insurance benefit as a retired worker and wife's (or husband's) insurance benefit as the spouse of a retired worker cannot apply for just one of the benefits; when she applies for one she is deemed to have applied for both. As a result, such a person who claims benefits before age 65 has both of her benefits actuarially reduced.

Also under present law, a wife who has worked and becomes eligible for an old-age insurance benefit on her own earnings, who takes that benefit before age 65, and who later becomes eligible for a wife's benefit when her husband applies for his retirement benefit can get a lower wife's benefit (on account of the reduction that was made in her old-age insurance benefit because it was paid before age 65) than does a wife who never worked under the program. (This situation does not occur under present law when a woman getting wife's insurance benefits later becomes eligible for an old-age insurance benefit; the reduction in her wife's benefit is disregarded in figuring the amount of her old-age insurance benefit.) Present law also provides that if a woman takes a widow's insurance benefit before age 62 and later gets a disability or old-age insurance benefit, the later benefit is reduced to take account of the prior receipt of the reduced widow's benefit.

***5033** Under the bill, the so-called 'deemed filing' provision would be removed from present law. A person eligible for benefits as a retired worker and also as a spouse could choose to take only one of the benefits and claim the other one later, or he could take both benefits at the same time.

In addition, the bill would modify the provision in present law under which a person cannot become entitled to a dependent's benefit if the primary insurance amount on which his own benefit is based is equal to or greater than the amount of his full dependent's benefit. However, as under present law, only one benefit, in effect, would be paid.

Also under the bill, the reduction that is made in one benefit would not lower the amount of a benefit that is taken later.

Examples showing the effect of these changes follow:

Example 1.-- A woman is potentially eligible for an old-age benefit and a wife's benefit at age 62. Her unreduced old-age benefit, payable if the benefit begins at or after age 65, is $78. Her husband's unreduced benefit is $198. Her unreduced wife's benefit is $21-- one-half of her husband's $198 benefit ($99) minus her own unreduced benefit of $78. Her combined unreduced old-age benefit and wife's benefit would be $99-- her own benefit of $78 plus her wife's benefit of $21.

She applies for reduced benefits at age 62 and, under present law, must apply for both benefits. Her old-age benefit is 80 percent of $78, or $62.40. Her wife's benefit is 75 percent of $21, or $15.80. Her combined old-age benefit and wife's benefit beginning at age 62 is $78.20.

Under the committee's bill she could restrict her application at age 62, take only one of her benefits and wait until later to file for the other. She could take her reduced old-age insurance benefit, get $62.40 a month at age 62, and wait until age 65 to claim her wife's benefit, and get $99 a month from age 65 on.

Example 2.-- Under present law, a woman is eligible for her own old-age insurance benefit at age 62. Her husband has not yet applied for benefits so she is not eligible for a wife's benefit. Her old-age insurance benefit at age 65 would be $78; she chooses to take it at age 62 and gets a reduced benefit of $62.40. When she reaches age 65, her husband retires, applies for benefits, and becomes entitled to an old-age benefit of $198. She applies for wife's benefits and becomes entitled to a wife's benefit of $21-- one-half of her husband's $198 benefit, or $99, minus her own unreduced benefit of $78. If she had not taken her own benefit at age 62, she would get $99 a month under present law. Because she did take her own benefit at age 62, she can get only $83.40 starting at age 65-- $62.40 plus $21.

Under the bill, she would get a benefit of $99 a month starting at age 65 even though she elected to take her reduced old-age benefit at age 65.

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The new provisions would apply to people who become entitled to benefits for or after the sixth month after the month of enactment. People already on the benefit rolls when the provisions become effective could, upon request, have their benefits redetermined under the new provisions. Even if a person's own old-age benefit was larger than his benefit as a spouse at the time of initial entitlement, the redetermination could be made as if the person had elected the smaller spouse's benefit first and his own old-age insurance benefit at age 65.

***5034** In some cases the application of this provision would mean that a beneficiary should not have been entitled to some of the benefits he had been paid. If these beneficiaries wish to be paid the higher benefits provided uner the bill, they would be required under a spcial repayment provision to repay the benefits they are no longer entitled to have been paid. The repayment would be accomplished by withholding payment of the amount of the increase in benefits that would occur under the provision until recovery is made of the excess of the amount the beneficiary was actually paid over the amount he would have been in effect at the time of his original application.

An illustration of how the recovery would be accomplished is as follows:

In the first example above, the woman could, under the provisions of the bill, request to have her benefit redetermined under the new provisions. As a result of this redetermination, her month of entitlement to wife's benefits could be changed from the month in which she reached age 62 to the month in which she reached age 65. With this change, the amount of her monthly benefit would have been $62.40 (instead of $78.20) a month from age 62 to age 65 and $99 (instead of $78.20) a month from age 65 on.

Assume she is age 66 when the redetermination is made. If the bill had been in effect she would have been paid, for the 48 months from age 62 to age 66 for which she has been paid benefits, $62.40 a month for the 36 months from age 62 to age 65, and $99 a month for the 12 months from age 65 to age 66, a total of $3,434.40. She would actually have been paid $78.20 a month for all 48 months, or $3,753.60. Thus, she would have been paid a total of $319.20 more under present law than she would have been paid if the bill had been in effect throughout the 48-month period. The $20.80 increase in her benefit, from $78.20 to $99, would be withheld and not paid to her until the $319.20 has been recovered-- in about 16 months. From that point on she would get a monthly benefit of $99. If she should die or become entitled to another benefit (for example, a widow's benefit based on her husband's earnings) before the $319.20 is entirely recovered, the amount not recovered would be waived.

The bill would make no change in the provisions of present law under which a person entitled to both an old-age insurance benefit and a wife's or dependent husband's insurance benefit may not get both benefits in full. Under the law, a worker always gets the old-age insurance benefit he earns for himself; if that benefit is higher than the benefit he is potentially eligible for as a wife or dependent husband, the latter benefit is not payable. If the worker's old-age insurance benefit is less than the wife's or dependent husband's benefit payable on the spouse's earnings, the difference between the two benefits is paid

Approximately 100,000 beneficiaries on the rolls would be immediately affected by this provision and $20 million in additional benefits would be paid in the first full year.

Benefits based on combined earnings for a couple

Under the present social security law, a working couple may be paid less in total retirement benefits than another couple with the same total earnings where only the husband worked. For example, where only the husband works and has average yearly earnings of $6000, the benefit ***5035** paid to the couple at age 65 would be $224.70 to the husband and $112.40 to the wife, a total of $337.10; if the husband had had average earnings of $4000 and the wife had had average yearly earnings of $2000-- combined earnings of $6000-- his benefit would be $171.50 and hers would be $118.00, a total of $289.50-- $47.60 less than the couple with the same total average earnings when only the husband worked. Your committee's bill would permit the payment of benefits based on the combined earnings of a married couple. The new computation could be used only if both the husband and wife reach age 62 after 1971, are insured for old-age benefits, and have 20 or more years of coverage under the social security program after they were married. (Other dependents' benefits would continue to be computed as under the present law.) A year of coverage would be defined in the same way as it is defined under the new special minimum provision.

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The earnings of the man and wife in each year would be combined up to the maximum amount of annual earnings that is creditable for social security purposes for the year. for example, if the man had maximum earnings in, say, 1968 ($7800) and his wife had earnings of $3000 in the same year, they could get credit for only $7800 for that year in combined earnings. On the other hand, if the man and his wife each had earnings of $3000 in 1968, all of their earnings ($6000) for the year would be credited. When the husband and wife have different computation periods (because of a difference in their ages or entitlement to disability benefits) the average monthly earnings on which the combined benefits would be based would be averaged over the longer of the two periods.

The total benefits payable to a couple would be equal to 150 percent (75 percent for each member) of the amount that would be paid to a single person with an average monthly wage equal to the couple's combined wage. This 150 percent total is equal to what is paid to a couple under present law and would be divided equally between the husband and the wife, and each would be paid an old-age insurance benefit. If either were entitled to disability insurance benefits, the disability benefit would be paid up to age 65, as under present law.

The provision would apply only if the husband and wife both elected to have their earnings combined, and once the couple elected to have their earnings combined, the arrangement would be permanent unless they are divorced or one member of the couple dies.

Because each person (except when disability benefits are paid) getting benefits based on combined earnings would be receiving an old-age insurance benefit, benefits starting before age 65 would be reduced under the provisions of present law which apply to old-age insurance beneficiaries. In addition, the retirement test would be applied to each as it is under present law to people entitled to old-age benefits.

When a benefit based on combined earnings has been paid and either the husband or wife dies, the widow's (or dependent widower's) benefit would be computed as under present law, except that the benefit would never be less than the amount based on the combined earnings that the survivor had been receiving before the death of the spouse. Thus, a widow would get a benefit equal to the largest of (A) the old-age benefit that was paid to her under the combined earnings computation, (B) the benefit that could be paid to her on the basis of her own earnings without regard to the combined-earnings provision, or (C) the widow's benefit payable to her without regard to the combined-earnings provision.

***5036** Liberalization of the retirement test

Under present law, if a beneficiary under age 72 earns more than $1,680 in a year, $1 less in benefits is paid for each $2 of earnings between $1,680 and $2,880 and for each $1 of earnings above $2,880. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages of more than $140 nor renders substantial services in self-employment. Under the bill, beginning in 1972, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed $2,000; the bill would also increase from $140 to $166.66 2/3 the amount of wages a beneficiary may earn in a given month and still get full benefits for that month. In addition, your committee's bill would provide that only $1 in benefits would be withheld for each $2 of earnings above $2,000, regardless of how high the earnings might be. This change would assure that the more a beneficiary works and earns, the more spendable income (that is, social security benefits plus earnings after taxes) he will have.

The bill would also change the retirement test as it applies in the year in which a worker reaches age 72. Under present law, benefits are not withheld under the test for months when the person is age 72 or older. However, in the year in which a beneficiary reaches age 72, earnings in and after the month in which he reaches age 72 are counted in determining his annual earnings and thus have an effect on whether benefits are reduced or withheld for the months before he reached age 72. Many beneficiaries believe that earnings after they reach age 72 are not counted under the retirement test; as a result, they are entitled to less in benefits than they expected and some may find that they have been overpaid because of this misunderstanding. Your committee's bill would provide that only amounts earned before the month in which the beneficiary became 72 would be used in determining his earnings for the year. A self-employed person would have his self-employment earnings for the year prorated to each month in his taxable year, in applying the provision.

Dependent widower's benefits at age 60

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Under present law, an aged widow can become entitled to widow's insurance benefits at age 60, but an aged dependent widower cannot become entitled to dependent wiodwer's benefits until age 62. The 1965 amendments lowered the age of eligibility for widows from 62 to 60 but did not change the age of eligibility for dependent widowers.

The committee believes that the age of eligibility should be the same for aged dependent widowers as for aged widows. Accordingly, the bill would lower the age of eligibility for aged dependent widower's benefits from 62 to 60. The benefits payable to an aged dependent widower who starts getting benefits before age 62 would be actuarially reduced, as are the benefits under present law for aged widows who come on the benefit rolls before age 62.

Because the benefit amount payable at age 60 would be reduced to take account of the longer period over which benefits would be paid, the payment of these benefits would not result in any additional long-range cost to the program.

Childhood disability benefits

Under present law, a person can qualify for childhood disability benefits if he has been continuously disabled-- as defined in the law-- ***5037** since before age 18 and is still disabled when his parent dies or becomes entitled to social security benefits. Your committee's bill would permit the payment of childhood disability benefits when the disability begins before age 22, rather than before age 18.

People under age 22 who become so seriously disabled that they are prevented from working generally depend on their parents for their future support. Your committee believes that it is appropriate and desirable to provide social security benefits for these disabled people after the insured parent dies, becomes disabled, or retires.

Your committee's bill would also permit reentitlement to childhood disability benefits for a person who had been entitled to childhood disability benefits and who again becomes disabled within 7 years after his benefits were terminated because of a period of substantial gainful employment or medical recovery. This change would afford a former childhood disability beneficiary an opportunity to work long enough to gain disability protection as a worker. Such a change would be consistent with present law which permits disabled widows and widowers to become reentitled to benefits if they again become disabled after recovering from an earlier disability.

These provisions would be effective with respect to benefits for months after December 1971. About 13,000 people-- disabled children and their mothers-- would immediately become eligible for benefits. About $14 million in additional benefits would be paid out during the first full year.

Continuation of child's benefits through the end of a semester

Under present law, the child's benefits paid to a full-time student end with the month in which he reaches age 22. Your committee believes that this provision of the law causes an unnecessary hardship for students who reach age 22 during a school term. Accordingly, your committee's bill includes a provision, effective in January 1972, under which the payment of benefits to a student who has not received, or completed the requirements for, a degree from a 4-year college or university would continue through the end of the school term. Accordingly, your committee's bill includes a provision, effective in January 1972, under which the payment of benefits to a student who has not received, or completed the requirements for, a degree from a 4-year college or university would continue through the end of the school term in which his 22d birthday occurs. If the educational institution in which he is enrolled is not operated on a semester or quarter system, benefits would continue until the month following the completion of the course in which he is enrolled or for two calendar months after the month in which he reached age 22, whichever occurs first.

During the first full year about 55,000 students would have their benefits continued under this provision; about $16 million in additional benefits would be paid out in the first full year.

Benefits for a child entitled on the record of more than one worker

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Under present law, a child entitled to benefits based on the earnings record of more than one worker gets benefits on only one earnings record-- the record of the worker with the highest primary insurance amount.

In cases where a child is entitled to benefits based on the earnings record of more than one worker who has the highest primary insurance amount is sometimes smaller than the benefit based on the earnings record of another worker on whose record he is also entitled. He is, however, paid the smaller amount.

This situation can arise because a child who is entitled to benefits based on the earnings record of a retired or disabled worker gets a ***5038** benefit equal to 50 percent of the worker's primary insurance amount, while a child who is entitled to benefits based on the earnings record of a deceased worker gets a benefit equal to 75 percent of the deceased worker's primary insurance amount.

When the present provision was enacted, a child's benefit was always 50 percent of the worker's primary insurance amount, whether the worker was living or dead, so that the highest possible benefit was always the benefit based on the highest primary insurance amount. Subsequent changes increased a surviving child's benefit (but not that for a child of a living worker) to 75 percent of the primary insurance amount.

The bill would provide that a child who is entitled to benefits on the earnings record of more than one worker would get benefits based on the earnings record which results in paying him the highest amount, if the payment would reduce the benefit of any other individual who is entitled to benefits based on that earnings record. (Entitlement of a child on the earnings record that will give the child the highest benefit could otherwise result in a reduction of the benefits for other people entitled on the same earnings record because of the family maximum limitation.)

The provision would be effective for January 1972.

Eligibility of a child adopted by an old-age or disability insurance beneficiary

Your committee's bill would change the eligibility requirements for child's benefits in the case of adoption by old-age and disability insurance beneficiaries to provide uniform rules. Under present law, a child (other than a natural child or a stepchild) who is adopted by a worker getting old-age insurance benefits can get child's benefits based on the worker's earnings if the following conditions are met:

(1) the adoption took place within 2 years after the worker became entitled to old-age benefits,

(2) the child was receiving at least one-half of his support from the worker for the year before the worker became entitled to benefits, and

(3) either the child was living with the worker in or before the month in which the worker filed application for old-age benefits or the worker had instituted adoption proceedings in or before that month.

There is no provision in the law which would allow a child to get child's benefits when he is adopted by a worker more than 2 years after the worker becomes entitled to old-age benefits.

In contrast, a child who is adopted by a worker getting disability insurance benefits can get benefits regardless of whether he was being supported by the worker when the worker became disabled, and regardless of when the adoption took place, if all of the following requirements are met:

(1) The adoption took place under the supervision of a child-placement agency;

(2) The adoption was decreed by a court of competent jurisdiction within the United States;

(3) The worker resided continuously in the United States for at least 1 year immediately preceding the adoption; and

(4) The adoption occurred prior to the child's reaching age 18.

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Alternatively, if the child was adopted by a worker getting disability insurance benefits within 2 years after the worker began to get ***5039** benefits, the child can get benefits if either the worker instituted adoption proceedings in or before the month when he became disabled or the child was living with the worker in that month.

Your committee believes that the provisions described above are unnecessarily complex and that the law should be changed so that eligibility of children adopted by retired workers and children adopted by disabled workers would be determined under common rules. At the same time, your committee believes that benefits for a child who is adopted by a worker already getting old-age or disability benefits should be paid only when the child lost a source of support because his parent retired or became disabled, and that the law should include safeguards against abuse through adoption of children solely to qualify them for benefits. The committee has included in the bill a provision that it believes will accomplish these objectives.

Under the bill, benefits would be payable to a child who is adopted by an old-age or disability insurance beneficiary if the following conditions are met:

(1) The child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit;

(2) The child received at least one-half of his support from the worker for that year;

(3) The child was under age 18 at the time he began living with the worker; and

(4) The adoption was decreed by a court of competent jurisdiction within the United States.

A child who was born in the 1-year period during which he would otherwise be required to have been living with and receiving at least one-half of his support from the beneficiary would be deemed to meet the living-with and support requirements if he was living with the beneficiary in the United States and receiving at least one-half of his support from the beneficiary for substantially all of the period occurring after the child was born.

The provision would be effective for benefits for January 1968 if an application is filed before the close of the sixth month after the month of enactment. Otherwise the provision would be effective on enactment.

Nontermination of child's benefit by reason of adoption

Under present law, a child's entitlement of benefits ends if he is adopted unless he is adopted by (1) his natural parent, (2) his natural parent's spouse jointly with the natural parent, (3) the worker (e.g., a stepparent) on whose earnings the child is getting benefits, or (4) a stepparent, grandparent, aunt, uncle, brother, or sister after the death of the worker on whose earnings the child is getting benefits.

Your committee believes that in many cases adoptions by a relative more distant than those specified in the law or by an unrelated person are undertaken to secure for a child the legal and psychological advantages of adoption within a close family group and that it is inappropriate to deprive the child of his social security benefits because of these adoptions. Accordingly, the bill provides for the continuation of the payment of benefits to an entitled child who is adopted, regardless of who adopts him.

The provision would be effective with the month the bill is enacted. A child whose entitlement to benefits was terminated because he ***5040** was adopted and who, except for such adoption, would still be entitled to benefits may, upon filing proper application, become re-entitled to benefits.

Benefits for a child based on the earnings record of a grandparent

Your committee's bill adds a new provision to the law so that the grandchild of a worker (or of his spouse) can, under certain circumstances, qualify for child's insurance benefits. There is no provision now in the law that provides benefits for a child

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based on the earnings of a person other than his parent or stepparent.

Your committee believes that the present provisions do not provide sufficient protection for many children. There are a significant number of children whose parents are deceased and who are cared for and supported by a grandparent. It seems reasonable and equitable to provide benefits for a child in such cases when his grandparent retires, becomes disabled or dies. Your committee has included in its bill a provision that would accomplish this objective.

Your committee's bill also modifies the benefit eligibility requirements, as they would apply to grandchildren, for a child who is adopted after a worker's death by his surviving spouse. In order to qualify for benefits under present law, the child must be adopted within 2 years of the worker's death if the worker had not instituted adoption proceedings before his death, and the child must not have been receiving regular contributions toward his support from any person other than the worker or his spouse or from a public or private welfare organization which furnishes services or assistance for children. Your committee believes that while these requirements are appropriate and desirable in most cases, they are too restrictive for grandchildren and serve to deny benefits to grandchildren in cases where benefits ought to be paid. Accordingly, your committee's bill would modify these requirements as they would apply to grandchildren.

Under your committee's bill, a grandchild of a worker, or of his spouse, could qualify for child's insurance benefits if: (1) the child was living with, and receiving at least one-half of his support from the worker for the year immediately before the worker became disabled, or became entitled to old-age or disability insurance benefits, or died; (2) the child began living with the worker before he attained age 18; and (3) at the time the worker became disabled or became entitled to old-age or disability benefits or died the child's natural or adopting parents or stepparents were not alive, or the child was adopted by the worker's surviving spouse after the worker's death and the child's natural or adopting parent or stepparent was not living in the worker's household and making regular contributions toward the child's support at the time the worker died.

A child who was born in the 1-year period during which he would otherwise be required to have been living with and receiving at least one-half of his support from the grandparent would be deemed to meet the requirement if he was living with the grandparent in the United States and receiving at least one-half of his support from the grandparent for substantially all of the period occurring after the child was born.

The provision would be effective for months after December 1971.

Evidence of adoption for child's insurance benefits

Your committee has been informed that under certain circumstances some applicants for child's insurance benefits have had serious problems ***5041** complying with the current practices of the Social Security Administration relating to evidence of adoption. It is not always possible for people to supply a certified copy of an adoption decree issued by a proper court because, some courts seal the adoption records and generally will not issue the certified copies called for by the regulations. In order to cure this situation, the committee received proposals for remedial legislation. During consideration of these legislative proposals, the committee was assured by officials of the Department of Health, Education, and Welfare that the regulations would be changed to provide specifically that a birth certificate issued as a result of the adoption would be considered adequate evidence of the adoption in every case. Because of this assurance, your committee is not recommending a legislative cure for this problem at this time.

Elimination of the support requirements for divorced women

Your committee is concerned that there are a number of divorced women who cannot qualify for social security benefits because they cannot meet the support requirement in the law. Benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted at least 20 years before the divorce, and to a surviving divorced mother. In order to qualify for any of these benefits a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband; (2) she was receiving substantial contributions from her former husband pursuant to a written agreement; or (3) there was a court order in effect providing for substantial contributions to her support by her former husband.

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In some States the courts are prohibited from providing for alimony, and in these States a divorced woman is precluded from meeting the third support requirement. Even in States which allow alimony, the court may have decided at the time of the divorce that the wife was not in need of financial support. Moreover, a divorced woman's eligibility for social security benefits may depend on the advice she received at the time of her divorce. If a woman accepted a property settlement in lieu of alimony, she could, in effect, have disqualified herself for divorced wife's, divorced widow's, or surviving divorced mother's benefits.

The intent of providing benefits to divorced women is to protect women whose marriages are dissolved when they are far along in years-- particularly housewives who have not been able to work and that the support requirements of the law have operated to deprive some divorced women of the protection they should have received and, therefore, recommends that these requirements be eliminated, effective January 1, 1972. The requirement that the marriage of a divorced wife or widow must have lasted for at least 20 years before the divorce would not be changed.

About 10,000 women would immediately become eligible for benefits under this provision. About $18 million in benefits would be paid out in the first full year.

Waiver of duration-of-relationship requirement in certain cases of remarriage

To qualify for survivor's benefits under present law, a worker's widow or widower who is not the natural or adoptive parent of a child of the worker must have been married to the worker for a period of not ***5042** less than 9 months immediately prior to the day on which the worker died (except where death was accidental or in the line of duty in a Uniformed Service, in which case the period is 3 months). A stepchild must have been the stepchild of the worker for a similar period.

This duration-of-relationship requirement is included in the law as a general precaution against the payment of benefits where the marriage was undertaken to secure benefit rights. Your committee, however, believes that in certain situations the purpose of paying benefits to widows, widowers, and stepchildren is being defeated by the application of the duration of relationship requirements. In some cases of divorce and remarriage, the requirements were met at the time of the divorce but the subsequent remarriage was too recent for the requirements to be met on the basis of the time elapsing between the date of the remarriage and the date of the worker's death. It does not seem appropriate that benefits should be denied in such cases. Accordingly, your committee has included in its bill a provision which would waive, effective with benefits for January 1972, the duration-of-relationship requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild in cases where the worker and his spouse were previously married, divorced, and then remarried, the relationship existed at the time of the worker's death, and the duration-of-relationship requirement would have been met if the worker had died on the date when he was divorced from his spouse.

Waiting period for disability benefits

Your committee's bill would reduce the waiting period for disability insurance benefits by one month. Under present law, entitlement to disability benefits cannot begin until after a worker has been disabled throughout a waiting period of 6 consecutive full months. For example, if a worker becomes disabled on January 10, the waiting period is the 6 full months February through January 10, the waiting period is the 6 full months February through July; his first month of entitlement to benefits is August, and the first benefit check is payable early in September. No benefit is payable, however, unless the disability is expected to last (or has lasted) at least 12 consecutive months or to result in death; this latter provision would not be changed by your committee's bill.

While many workers have some protection against loss of income due to sickness or disability under various public or private plans (such as group policies, sick-leave plans, etc.), such protection usually expires before the end of the present disability waiting period. Reducing the waiting period from 6 months to 5 months would diminish the financial hardships faced by those workers who have little or no savings or other resources to fall back on during the early months of long-term total disability.

The provision would be effective January 1, 1972. About 950,000 people-- disabled workers and their dependents and disabled widows and widowers-- would receive increased benefits in the first full year as a result of this provision. About

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$105 million in additional benefits would be paid out during the first full year.

Disability insured status for individuals who are blind

To be insured for disability protection under present law, a worker must be fully insured and meet a requirement of substantial recent covered work. Generally, to meet the latter requirement, disabled ***5043** worker needs at least 20 quarters of social security coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled; a special provision takes into account the fact that workers who are disabled while young may have been in the work force for a relatively short time.

Your committee's bill would extend social security disability protection to additional blind persons by exempting them from the requirement of recent attachment to covered work. A blind person would be insured for social security disability benefits and a disability freeze if he is fully insured-- that is, he has quarters of coverage, acquired at any time, equal to the number of years elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled, except that he could not be insured with less than 6 quarters of coverage and would in no case need more than 40 quarters of coverage to be insured. This requirement would permit blind persons to be insured for disability protection on a basis comparable to that for retirement and survivor benefit protection. This seems to be a reasonable basis for qualifying for disability protection on the part of a blind individual who faces special employment problems.

The provision would be effective for January 1972. About 30,000 persons-- blind workers and their dependents-- would become immediately eligible for monthly benefits. About $29 million in additional benefits would be paid out during the first full year.

Application for disability benefits after disabled worker's death

Under present law, an application must be filed with the Social Security Administration to establish entitlement to social security disability insurance benefits by the disabled worker or, if he is unable to file an application, by another person on his behalf. In either event, entitlement to disability insurance benefits cannot be established unless the application is filed during the worker's lifetime.

In most cases a timely application is filed by or on behalf of a disabled worker who meets the other eligibility conditions of the law, so that the benefit rights of both the disabled worker and his dependents are protected. However, in a relatively few cases a disabled worker who would have been eligible for benefits dies before an application is filed and his disability benefit rights are lost. As a result, the living expenses of the disabled worker during the period of his disablement may remain unpaid and become obligations of his survivors.

Your committee has therefore included in the bill a provision which would permit disability insurance benefits to be paid if an application is filed within 3 months after the month of the death of a disabled worker. Benefit payments which would have been payable upon application by the disabled worker would then be payable for up to twelve months prior to the month in which an application is filed. An application filed within the 3-month period would also permit entitlement to dependents' benefits to be established.

The provision would apply in cases of deaths occurring after December 31, 1969. In cases in which the disabled worker died after December 31, 1969 but prior to enactment of the bill, an application could be filed within three months after the month of enactment and the application would be deemed to have been filed in the month of death.

***5044** Disability benefits affected by the receipt of workmen's compensation

Your committee's bill would modify present provisions under which social security disability benefits are reduced in some cases where the disabled worker is also receiving workmen's compensation.

Under present law, when a disabled worker qualifies for both workmen's compensation and social security disability benefits,

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the social security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two programs exceed 80 percent of his average current earnings before he became disabled. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his social security benefits, or (b) his average monthly earnings in employment or self-employment covered by social security during the 5 consecutive years of highest covered earnings after 1950, computed without regard to the limitations which specify a maximum amount of earnings creditable and taxable under social security. The objective of these provisions is to avoid the payment of combined amounts of social security benefits and workmen's compensation payments that would be excessive in comparison with the beneficiary's earnings before he became disabled.

While your committee subscribes to the principle underlying the offset provisions-- that the combined benefits should be somewhat less than the worker's earnings before he became disabled-- it believes that the computation of average current earnings does not, in some cases, realistically reflect the worker's earnings level before he became disabled. The bill therefore provides a third alternative, under which a worker's average earnings could be based on his highest year's earnings in the period consisting of the calendar year in which he became disabled and the 5 years immediately preceding that year.

The new provision is applicable to monthly benefits for months after December 1971.

Wage credits for members of the uniformed services

Under present law, social security coverage is provided on a contributory basis for people who serve in the uniformed services after 1956. The 1967 **social security amendments** provided (in addition to the contributory coverage of basic pay) noncontributory wage credits, usually $300 for each calendar quarter of military service after 1967, to take account of the wages in kind that servicemen receive.

The bill would extend the 1967 provision to cover service during the period 1957-67. This would provide noncontributor credit for service on active duty for all years that military service has been covered under social security, and would avoid the serious impairment of social security protection that now exists for those people (and their families) whose benefits are based on basic pay only for years of military service during the period from 1957 through 1967.

Your committee's bill also would simplify the way the wage credit is computed. Under present law, a member of a uniformed service receives a noncontributory wage credit of $100 for any calendar quarter in which his basic pay for the quarter was $100 or less, $200 for any calendar quarter in which his basic pay was more than $100 but not more than $200, and $300 for any calendar quarter in which his basis pay was more than $200. Under the bill, the noncontributory wage credits would be $300 for every calendar quarter of service in which a person receives basic pay, regardless of the amount of basic pay.

***5045** The cost of additional social security benefits that would be paid as a result of the enactment of these provisions would be financed from general revenues, on the same basis as the benefits resulting from the present noncontributory wage credits for years after 1967.

Optional determination of self-employment earnings

The present law provides social security credit to self-employed people on the basis of their net earnings from the operation of a trade or business. However, no credit is allowed for any year unless net earnings are at least $400 for the taxable year. An optional method of determining self-employment earnings is provided for farmers. The option provides that when a farmer's gross income:

(1) is not more than $2,400, his net earnings may, at his option, be deemed to be two-thirds of the gross income; or

(2) is more than $2,400 and the net earnings are less than $1,600, his net earnings may, at his option, be deemed to be $1,600.

When this optional method is used to determine self-employment earnings no social security credit is given if the deemed self-employment earnings are less than $400.

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Your committee believes that a similar option should be provided for all self-employed people. The bill, therefore, would provide an option that may be used by people who are regularly self-employed. The option would permit them to determine their nonfarm self-employment earnings for social security purposes as the smaller of: (1) their gross income or (2) $1600. The nonfarm option, however, could not be used more than 5 times by any self-employed person, and it could be used in any taxable year only if the person had actual net earnings from self-employment of $400 or more in at least 2 out of the 3 immediately preceding taxable years. An individual could use the optional method only if his actual net earnings from nonfarm self-employment were less than $1600 and less than two-thirds of his gross social security taxes on an amount less than his actual net earnings. These limitations should assure that the special method of determining net earnings from nonfarm self employment would not be available to people who may have insubstantial amounts of income in a year from a hobby or similar activity.

This provision would be effective for taxable years beginning after 1971.

Payments by an employer to the survivor or estate of a former employee

Under present law, social security taxes must be paid on wages paid to an employee's estate or survivor after the year the employee dies even though the wages cannot be used to determine eligibility for or the amount of social security benefits. These provisions have worked a hardship, particularly in the case of deceased life insurance salesmen whose renewal commissions have been taxed for many years after their death without increasing the social security benefits of their survivors. Accordingly, your committee's bill would exclude from the definition of wages amounts earned by a worker in covered employment which are paid after the year in which he died.

The provision would be effective with regard to any payment made after December 1971.

Coverage of members of religious orders who have taken a vow of poverty

Under present law, the services performed by a member of a religious order who has taken a vow of poverty which are in the exercise ***5046** of the duties required by the order are excluded from coverage under social security. Your committee's bill provides that such service would be covered under social security as employment for the order (or for an autonomous subdivision of the order) if the order (or subdivision) irrevocably elects coverage for its entire active membership, and if the order also makes an irrevocable election to cover its lay employees.

In 1967 the House passed legislation extending social security coverage to members of religious orders under a vow of poverty. However, when the matter was considered in the Senate, representatives of religious orders requested time for further study of the effects of coverage. The provision was not included in the Senate-passed bill which went to conference and the conference agreed to postpone the coverage to members of religious orders which is included in your committee's bill takes into account the recommendations which religious orders proposed after completing their study.

Your committee's bill provides that the wages for social security purposes would be the fair market value of any board, lodging, clothing, and other perquisites furnished to the member, and that the order which elects coverage would file social security reports on such wages and pay the employer and employee social security contributions on them. Your committee has been informed that the value of items furnished by an order do not vary significantly from member to member, so that the order would generally report a uniform wage for each member. The bill establishes $100 a month as the minimum amount of wages which may be reported by an order for each of its members. Your committee expects, however, that the minimum figure would not be used in those instances where it represents less than the fair market value of the items furnished the member.

Under present law, a nonprofit organization which provides coverage for its lay employees, and a State which provides coverage for its employees or the employees of any of its political subdivisions are permitted to provide the coverage retroactively for up to 5 years. Such a provision enables the employer to reduce the adverse effects of late entry into social security coverage on the newly covered employees. It seems reasonable to permit the religious orders, the same opportunity to protect their members. Accordingly, the bill would permit each order (or autonomous subdivision) to provide up to 5 years of retroactive coverage for those persons who were active members when the work was performed and who are alive when

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the election is made.

Improve coverage of U.S. citizens who are self-employed outside the United States and retain residence in the United States

Under present law, social security coverage of self-employment performed by a U.S. citizen outside the United States is subject to major restrictions because coverage is governed by provisions which were designed to define liability for income tax purposes. In computing earnings from self-employment, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for 510 days (approximately 17 months) out of 18 consecutive months, must exclude the first $20,000 of earned income for income tax and social security purposes.

Some self-employed U.S. citizens-- e.g., free-lance newspapermen or news commentators-- work outside the United States for long periods ***5047** at a time before returning to the United States. Such citizens usually had social security coverage before they went abroad. The interruption or reduction of their coverage, because they must exclude their earned income up to $20,000 a year, in some instances has an adverse effect on the social security protection of the worker and his family.

Your committee's bill provides that for social security purposes U.S. citizens who are self-employed outside the United States and who retain their residence in the United States will compute their net earnings from self employment in the same way as those who are self employed in the United States; the present exclusion for income tax purposes will no longer apply with respect to the self-employment tax but will continue to apply for income-tax purposes. The bill would not affect the exclusions (for either social security for income-tax purposes) taken by U.S. citizens who have established residence in a foreign country.

The provisions would be effective for taxable years beginning after 1971.

Coverage of Federal Home Loan Bank employees

The **Social Security Amendments** of 1956 provided for coverage of employees of the Federal Home Loan Banks on condition that their retirement system be coordinated with social security and that the plan for coordination be submitted to the Secretary of Health, Education, and Welfare and approved by him before July 1, 1975; this condition was not fulfilled.

The Federal Home Loan Bank Board has again requested that social security coverage be extended to the approximately 500 employees of Federal Home Loan Banks. These employees are eligible for retirement coverage under the Savings Association Retirement Fund which your committee is informed now provides coverage that is coordinated with the benefits provided under the social security program.

The bill would extend coverage to all services performed in the employ of a Federal Home Loan Bank starting with the first calendar quarter which begins on or after the date of enactment. Persons who are Bank employees on the first day of such calendar quarter would also have any services they performed in the employ of any of the Banks after the last day of the sixth calendar year before the year of enactment covered, but only if the employer and employee social security contributions on account of such services are paid by July 1, 1972, or by such later date as may be provided under an agreement entered into between the Banks and the Secretary of the Treasury.

Coverage of policemen and firemen in Idaho

The bill would make applicable to the State of Idaho the provision in the Social Security Act which makes social security coverage available, in certain jurisdictions specifically named in the law, to policemen and firemen who are in positions covered under a State or local retirement system, on much the same basis as to other persons under retirement systems. Under present law, the provision applies to 19 States, Puerto Rico, and to all interstate instrumentalities. The 19 States which are now included in the provision are Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington.

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In Idaho, and in other states not named in the law, social security coverage is not available to policemen who are in positions covered ***5048** under a State or local retirement system. It is available for firemen under a retirement system in these States, but only if special conditions set forth in the Federal law are met. The Governor of the State must certify that the overall benefit protection of the group of firemen which would be brought under coverage would be improved by reason of the extension of coverage to the group, and coverage can be extended only by means of a referendum in which only firemen may vote.

Coverage of certain hospital employees in New Mexico

Your committee's bill would permit the State of New Mexico, within 3 months after the month of enactment, to provide social security coverage, under its coverage agreement with the Secretary of Health, Education, and Welfare, for employees of certain public hospitals without regard to certain provisions of the Social Security Act which pertain to the conditions under which a State may bring a group of employees under social security coverage.

As a result of misunderstanding within the State, certain hospital employees were covered under the New Mexico Public Employees Retirement Association for a short period of time, although the coverage was unintended as far as the hospital and the hospital employees were concerned. This period of coverage under the State retirement security coverage because of the provisions of the Social Security Act that are designed to protect the rights of such employees against the replacement of coverage under a State or local government retirement system by social security coverage. The unusual situation in New Mexico is not the type of situation to which these provisions, designed to provide safeguards for retirement system members, were directed.

Coverage of certain employees of the Government of Guam

Employees of the Government of Guam are not covered under social security. (Employees of private employers in Guam have been covered since 1960 on the same basis as workers in the U.S.)

There are about 1,500 employees of the Government of Guam classified as temporary or intermittent employees who are not covered under social security and who are excluded from coverage under the government retirement system. As a result, they have no protection under any government retirement system. Under present law, social security coverage can be provided for these employees only if it is provided for employees covered under the Government of Guam retirement system. The Government of Guam has requested that coverage be provided for temporary and intermittent employees who are excluded from coverage under the government retirement system.

Your committee's bill would add a provision to cover on a compulsory basis the services of temporary and intermittent employees of the Government of Guam who are excluded from coverage under any retirement system established by the Governments of the United States of Guam. Services performed as members of the Legislature of Guam, or as an elected official, or in a hospital or penal institution by a patient or inmate thereof could not be covered under this amendment.

The provision would be effective for services performed on and after the first day of the calendar quarter which begins on or after the date of enactment.

***5049** Exclusion from coverage of students employed by a nonprofit organization auxiliary to schools, colleges, and universities

Under present law, services of a student performed in the employ of a private nonprofit organization which is auxiliary to a public or private school, college, or university at which the student is enrolled and in regular attendance are generally covered under social security. These auxiliary nonprofit organizations may operate such enterprises as bookstores, housing, publishing, or food service. It has come to the attention of your committee that an unfair situation exists when services performed by students in the employ of schools, colleges, or universities in which they are enrolled and in regular attendance are excluded from social security coverage while services performed by students for a nonprofit organization established for the benefit of the same schools, colleges, or universities are covered.

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Therefore, your committee's bill provides for the exclusion from social security coverage of services of students performed in the employ of an auxiliary nonprofit organization which is organized and operated exclusively for the benefit of and supervised or controlled by the school, college, or university. However, the provision would not exclude from coverage services of a student for an auxiliary nonprofit organization connected with a public school, college, or university whose student employees are covered under Social security pursuant to a State coverage agreement with the Secretary.

This provision would be effective with respect to services performed after December 31, 1971.

Coverage of Federal employment

Your committee has long been concerned because the exclusion of Federal civil service employment from social security coverage has given rise to inequities and gaps in protection involving large numbers of workers whose work is divided between periods of employment covered by social security and periods covered by the civil service system. In such cases, the resulting benefit protection for the worker and his family tends to be haphazard and uneven.

This situation has been studied over the years by the executive agencies that have responsibility for the social security and civil service retirement systems. Various proposals to coordinate the two systems in one way or another have been advanced. Although each of these proposals has had some merit, none has been completely acceptable.

The most recent recommendation was made by the 1971 Advisory Council on Social Security. It included in its report a recommendation that Congress consider a modification of an earlier proposal for service retirement systems. Under the Council's recommendations, civil service earnings credits would be transferred to the social security system when there is no eligibility under the civil service system and social security credits would be transferred to the civil service system when a person eligible under that system was not also eligible under social security. This recommendation was presented to the committee late in its consideration of the current legislation. There was insufficient time for the committee to consider the complex issues involved. Moreover, the legislation would require amendments to both the civil service and social security laws and any recommendation to amend the Civil Service Retirement Act would have to be approved by the Committee on Post Office and Civil Service.

***5050** Accordingly, your committee has directed the Social Security Administration to give further study to ways in which an acceptable, limited coordination between the two programs could be achieved. The committee has instructed the Social Security Administration to work with the staffs of this committee and the Committee on Post Office and Civil Service in formulating a workable plan and to consult with and obtain the views of the Civil Service Commission and organizations of federal employees on what would constitute a workable proposal. The results of this study are to be submitted to the Congress not later than July 1, 1972.

Penalty for furnishing false information to obtain a social security number

Under present law, criminal penalties are provided for any person who makes a false representation to obtain payment of social security benefits which are not due him. These penalties may be applied, for example, if a person attempts to get benefits based on his own earnings under more than one social security number, or to avoid having his benefits withheld under the retirement test by drawing benefits under one number while continuing to work for high earnings under a false name and another number, or to continue to draw disability benefits while engaged in substantial gainful employment under another name and number. Penalties are not provided in the social security law for those individuals who give false information in order to secure multiple social security numbers with an intent to conceal their true identities.

The use of false names, aided by a social security number issued in false names, has led to a number of problems in both private business and the administration of Government programs. Therefore, the bill would provide criminal penalties if an individual, with intent to deceive the Secretary of Health, Education, and Welfare as to his true identity, knowingly and willfully furnishes false information on an application for a social security number for the purpose of obtaining more than one number of of establishing a social security record under a different name. The penalty would not be applicable, however, if the person obtaining more than one social security number provides sufficient information to permit the Social Security

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Administration to identify all the numbers issued to such person so that all of his wage credits may be combined.

Guarantee that no family would have its total family benefits decreased as a result of an increase in the worker's benefit

In the past when general benefit increases have been enacted it has been possible, in certain cases, for a family on the benefit rolls when the increase is effective to have the total family benefits decreased slightly. Such a decrease can also occur under present law when a worker's benefit is increased as a result of a recomputation of his benefit amount to include additional earnings. Those decreases occur in cases where the family maximum provision applies and the worker's benefit is actuarially reduced (because it started before age 65).

A special provision was included in the 1969 amendments to prevent a decrease in total family benefits from occurring under the general benefit increase that was included in those amendments. But the provision was only temporary in effect-- it applied only to the general benefit increase under the 1969 amendments, and only so long as at least one family member who was entitled before January 1971 on the basis of an application filed before January 1971 continues to get benefits.

***5051** The bill provides that no family would have its total family benefits decreased because of an increase in the worker's benefit resulting from any general benefit increase that may be effective in the future or from a recomputation of the worker's benefit to include additional earnings and also makes the special provision included in the 1969 amendments permanent.

Increase of amounts in trust funds available to pay costs of rehabilitation services

Your committee's bill includes a provision which is intended to increase the number of social security disability beneficiaries who are rehabilitated and enabled to return to gainful employment. Under present law, the total amount of trust fund money that may be used in any year for reimbursing State agencies for the costs of rehabilitation services provided disability beneficiaries may not exceed 1 percent of the social security disability benefits paid in the previous year. Your committee's bill would increase the authorization for use of trust fund money for rehabilitation in two steps-- to 1.25 percent for fiscal year 1972, and to 1.5 percent for fiscal year 1973 and subsequent years. The Department of Health, Education, and Welfare has informed your committee that the savings to the trust funds resulting from the increased number of disability beneficiaries who would be rehabilitated and returned to employment would substantially exceed the additional costs of the rehabilitation services.

Authorization for the Managing Trustee of the social security trust funds to accept money gifts

There is no authorization in the law for the Managing Trustee of the social security trust funds (by law, the Secretary of the Treasury) to accept gifts and bequests made to the social security program. While unrestricted bequests can be deposited in the general funds of the Federal Government, bequests restricted to the social security program cannot be accepted without enactment of special legislation.

There is precedent in the law for the Government to accept gifts for special purposes. The Secretary of Health, Education, and Welfare can accept gifts for certain divisions of the Public Health Service (such as the National Library of Medicine, the National Cancer Institute, the National Heart Institute, and St. Elizabeths Hospital), and the Cuban refugee program.

There have been some cases where money has been bequeathed to the social security trust funds. Because such a bequest cannot be accepted, confusion and delay in settling the estate may result. The Department points out that while the amount of money lost to the trust funds is insignificant, it seems unjustifiable that an act presumably motivated by appreciation for, and confidence in, a Government program should cause complicated and perhaps interminable legal problems for the survivors.

Your committee's bill, therefore, includes a provision which would authorize the Managing Trustee of the social security trust funds to accept money gifts or bequests made unconditionally to the trust funds or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of any of the social security trust funds or any activity financed through such funds, and to deposit such gifts or bequests in the social security trust funds.

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Under this amendment, gifts would be credited to the particular trust fund designated by the donor (the old-age and survivors insurance ***5052** trust fund, the disability insurance trust fund, the hospital insurance trust fund, or the supplementary medical insurance trust fund). If no fund is designated, the gift would be credited to the old-age and survivors insurance trust fund.

Recomputation of benefits based on combined railroad and social security earnings

A social security beneficiary may receive benefits in a given year based only on earnings in prior years; but his primary insurance amount is automatically recomputed from year to year if he has current earnings. Recomputation is provided for 'if an individual has wages or self-employment income for a year after 1965'. This wording has inadvertently created a problem when people are entitled to benefits under both the social security and railroad retirement systems.

A living individual with entitlement to both social security and railroad retirement benefits may receive benefits separately under both systems. If he dies, however, his survivors may receive benefits from only one system, based on his combined earnings under both systems. Thus, upon his death a recomputation is necessary. The language of the law has been interpreted as preventing the Social Security Administration from automatically recomputing survivor earnings where the deceased person retired before 1966 and had no earnings after 1965. A specific provision in the law is needed to make it clear that survivor's benefits will continue to be based on the worker's combined social security and railroad earnings.

The bill would provide that a deceased individual who during his lifetime was entitled to social security benefits and railroad compensation and whose railroad remuneration and earnings under social security are, upon his death, to be combined for social security purposes would have his primary insurance amount recomputed on the basis of his combined earnings, whether or not he had earnings after 1965.

Retroactive payment of disability benefits

Under a 1967 amendment certain disabled people were allowed to establish a period of disability-- the so-called disability freeze-- even though the period provided in the law for filing effective applications had terminated. This 1967 provision was designed to protect a limited number of people who, when the disability program was new, had been so severely disabled that they did not have the opportunity or ability to file an application.

Your committee has been informed that these people also lost benefits which would otherwise have been paid. Therefore, your committee's bill would provide for the payment of cash disability benefits for periods of disability prior to 1968 that have been established by those persons under the 1967 amendment.

B. PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

1. Eligibility and payment for benefits

(a) Coverage for disability beneficiaries under medicare.-- Over the years your committee has given extensive consideration to proposals ***5053** to provide health insurance protection under title XVIII for persons entitled as a result of disability to monthly cash benefits under the social security and railroad retirement programs. While your committee has always believed that there are compelling reasons for extending the protection of medicare to disability beneficiaries, it has in past years regretfully concluded that considerations of cost precluded recommending such an extension of coverage. Your committee believes, however, that the present unmet need for health insurance protection among the disabled of our Nation is so great that appropriate legislative action should no longer be deferred.

In an effort to ascertain the dimensions of the health insurance problem confronting the disabled and to evaluate all the possible approaches to providing or assuring adequate health insurance for such people, your committee has in recent years directed a number of Advisory councils to study this question and to report their finding and recommendations to the Congress. In each case, the council charged with responsibility for examining the issue has recommended the extension of medicare coverage to the disabled. Moreover, your committee believes that the findings on which these councils based their recommendations are too impressive to be ignored or minimized. It is clear, for example, that a major unmet need for health

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insurance protection exists among the disabled. Use of health services by people who are severly disabled is substantially higher than that by the non-disabled. Disabled workers receiving cash benefits under the social security program use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. These facts account both for the great need for and the substantial costs of covering the disabled under medicare. Yet the disabled have limited incomes in comparison to those who are not disabled, and most disabled persons are unable financially to purchase adequate private health insurance protection, or to obtain such insurance at all.

Accordingly, your committee's bill would extend medicare protection to social security disability beneficiaries. Those covered would include disabled workers, disabled widows and disabled dependent widowers between the ages of 50 and 65, people aged 18 and over who receive social security benefits because they became disabled before reaching age 22, and disabled qualified railroad retirement annuitants.

While your committee has concluded that considerations of public policy dictate the extension of medicare protection to the disabled, your committee also believes, given the cost and financing considerations involved in such coverage, that it is imperative to proceed on a conservative basis. Consequently, your committee's bill would provide health insurance protection only after the disabled beneficiary has been entitled to social security disability benefits for not less than 24 consecutive months. Such an approach would help to keep program costs within reasonable bounds, avoid overlapping private health insurance protection, particularly in those cases where a disabled worker may continue his membership in a group insurance plan for a period of time following the onset of his disability, and minimize certain administrative problems that might otherwise arise in cases in which entitlement to disability benefits is not determined until some time after application is made because of delays due to the appellate process.

***5054** Moreover, this approach would provide assurance that the protection will be available to those whose disabilities have proven to be severe and long lasting.

Under this provision of your committee's bill, medicare protection would begin with the later of (a) July 1972, or (b) the 25th consecutive month of the individual's entitlement to social security disability benefits.

(b) Hospital insurance benefits for uninsured individuals not eligible under transitional provision.-- Present law provides hospital insurance protection under the 'special transitional provision' for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Employees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The 'special transitional provision' covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached age 65 before 1968 even though they had no work under social security (or in railroad industry). Those who attained or will attain age 65 after 1967 must have had specified amounts of work under these programs in order to be eligible for hospital insurance protection. The transitional provision will phrase out as of 1974 as persons attaining age 65 in that year must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the insured aged and to eventually phase out, a portion of the aged, though small in number (as of July 1, 1971, it is estimated that this portion will number approximately 344,000 or 1 1/4 percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 344,000 people include 50,000 recent immigrants, who would continue to be excluded from coverage; 150,000 active or retired Federal employees, who are not eligible for the transitional provisions; and 144,000 others.) Although these ineligibles include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

Further, it has become very difficult for many in this group to obtain private hospital insurance comparable to coverage under

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medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available ***5055** to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance, paying from $25 to $200 per week for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged.

Your committee's bill would make available hospital insurance coverage under medicare on a voluntary basis to persons age 65 and over, including Federal civil service employees or annuitants and their spouses, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group. The premium would be $31 a month beginning with January 1972 and up to and including June 1972, and would be recomputed each fiscal year and increased in the same proportion as the inpatient hospital deductible. The same restrictions on enrollment and reenrollment (including a 10-percent per year charge for late enrollment) would apply as now apply to enrollment for supplementary medical insurance (including the changes in such enrollment provisions made by other provisions in the bill).

Your committee's bill would provide that whenever a person enrolled for voluntary hospital insurance becomes eligible for such coverage as a result of becoming eligible for monthly cash social security or railroad retirement benefits or under the special transitional provision, his coverage under the provision would be terminated; and to insure that his hospital insurance coverage continued uninterrupted he would be deemed to have filed the applications required for establishing hospital insurance under the other provision in the month he becomes eligible under the other provision.

The effective date for coverage provided under this provision would be January 1, 1972.

(c) Amount of supplementary medical insurance premium-- Under present law, the Secretary of Health, Education, and Welfare is directed to determine and promulgate a premium in December of each year for individuals enrolled in the supplementary medical insurance program. The dollar amount of the premium is the amount the Secretary estimates to be necessary so that the aggregate premiums for the 12-month period commencing July 1 in the succeeding year will equal one-half of the total supplementary medical insurance program costs that will be payable during that fiscal year. (The Federal Government pays the other half of the costs by matching the premium amount paid by each enrollee.) During the first five years of the program it has been necessary to increase the premium almost 87 percent-- from $3 in July 1966 to a scheduled $5.60 rate as of July 1971.

Your committee is concerned about the increasing severe financial burden that the premium amount, established under this method, will come to represent in future years. The premium is not only likely to continue to rise significantly but will do so without regard to the ability of beneficiaries living on reduced retirement incomes to bear the increased financial burden.

Accordingly, under your committee's bill, the supplementary medical insurance premium generally would increase in any given year only if monthly cash social security benefits had been increased in the interval ***5056** since the premium was last increased. Moreover, the premium would rise by no more than the percentage by which cash benefits had been increased across the board (whether by act of Congress or automatically under the provision in the bill which provides automatic increases in cash benefits under certain circumstances). Thus, enrollment in the supplementary medical insurance program would remain voluntary and premium payments by enrollees would still be required, but premiums would be increased only at times and by amounts that would be related to the beneficiary's ability to meet the cost.

The revised procedure for establishing the medical insurance premium would operate as follows. The medical insurance premium would be allowed to rise to $5.60 on July 1, 1971, as presently scheduled. During December of 1971, and each year thereafter, the Secretary would be required, as he is under present law, to determine and promulgate the monthly premium amount for the 12-month period beginning the following July. As one step in determining the premium amount, however, he would determine a monthly actuarial rate for aged enrollees representing the dollar amount he estimates will equal in the aggregate over the 12-month period, one-half of the total benefit and administrative costs (plus a small contingency reserve) that the program will incur with respect to enrollees age 65 and over. The premium for all enrollees (including disability beneficiaries) would then be set to equal the lesser of (a) the actuarial rate described above or (b) the most recently

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promulgated premium rate, increased by the total percentage by which monthly cash benefits have increased or are scheduled to increase during the fiscal year to which such recently promulgated rate applies. When he promulgates the premium the Secretary would be required to issue a public statement setting forth the actuarial assumptions and bases used in arriving at the actuarial rate, and the ********** of the premium amount.

Your committee's bill would also authorize the appropriation from the general revenues of sufficient funds to meet all supplementary medical insurance program costs above those met by the aggregate premium amounts paid by aged and disabled enrollees.

(d) Change in supplementary medical insurance deductible.-- Under present law, a deductible is applied to the first $50 of expenses incurred by a beneficiary for services of the type covered under the supplementary medical insurance program.

Recognizing that medical costs have risen considerably since the beginning of the medicare program, your committee has concluded that it would be appropriate to increase the supplementary medical insurance deductible to $60 as of January 1, 1972. Thus, beneficiaries would continue to bear a reasonably representative portion of their medical insurance costs. The $60 figure is below the amount ($70) that would be necessary to maintain the same relationship between the deductible and program costs as existed between $50 and program costs when the program began.

(e) Increase in lifetime reserve days and change in hospital insurance coinsurance amount under medicare.-- Under present law, payment may be made for up to 90 days of inpatient hospital services furnished during a benefit period (spell of illness), with the beneficiary being responsible for an inpatient hospital deductible (currently $60) and, beginning with the 61st day of his stay, a daily coinsurance amount equal to one-fourth of the inpatient hospital deductible (now $15). In addition, present law provides each beneficiary with a nonrenewable ***5057** lifetime reserve of 60 days of inpatient hospital coverage upon which he may draw after having exhausted the 90 days of covered care regularly available to him in a benefit period; a coinsurance amount equal to one-half of the inpatient hospital deductible is applicable to each lifetime reserve day used.

Your committee believes there is a need to more fully protect medicare beneficiaries against the very high costs associated with those illnesses that require prolonged use of inpatient hospital services; it has also been mindful of the need to promote the most effective possible utilization of such services and to maintain an awareness of the cost of hospital care among the beneficiaries of the program. To further the objective of the medicare program to protect the aged against the very heavy expenses of major illness, your committee's bill would provide for an increase from 60 to 120 in the number of 'lifetime reserve' days for which inpatient hospital benefits may be paid. Thus, each medicare beneficiary would have available to him at least 210 days of covered hospitalization, even if he had only one benefit period. As under present law, to guard against any possible unnecessary utilization of services, the beneficiary would be responsible for a coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day used. Your committee believes that this increase in the lifetime reserve would sufficiently protect the large majority of beneficiaries against the most expensive illnesses without, however, disrupting the intended effect of the benefit period provision, which is to provide some objective means for discontinuing benefit payments in those cases where the individual is more or less permanently institutionalized.

Your committee has also examined the cost-sharing requirements that were established at the time of medicare's enactment in order to determine whether they were accomplishing their intended purposes. Based on its examination your committee has concluded that cost-sharing beginning at an earlier point in the benefit period than is required under present law would serve to increase the incentive for both beneficiaries and their physicians to participate in efforts to bring about more effective control of the utilization and cost of inhospital services. Your committee's bill provides for the application of a daily coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day of inpatient hospital coverage during a benefit period beginning with the 31st day and through the 60th day. The coinsurance amount for the 61st through the 90th day would remain, as under present law, equal to one-fourth of the inpatient hospital deductible. Present experience indicates that about 10 percent of the hospitalized aged use more than 30 days of hospital care during a benefit period and it may very well be that in some of those cases care beyond 30 days is really not needed.

These amendments would be effective with respect to inpatient hospital services furnished during hospital stays beginning after December 31, 1971.

(f) Automatic enrollment for supplementary medical insurance.-- Under present law an individual eligible for supplementary

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medical insurance must take the positive action of enrolling to obtain coverage for insurance. If he does not act within the time imposed by the law, he stands to lose several months of medical insurance coverage. In recognition of the importance of timely enrollment, a concerted effort is made to notify people of their opportunity to enroll ***5058** in medical insurance as they become eligible and, in fact, nearly 96 percent of eligible individuals are enrolled. Some few, however, fail to enroll at their first opportunity due, for example, to inattention, or because they are incapable of managing their own affairs.

Your committee believes, therefore, that it would be good public policy to assure that individuals are enrolled for supplementary medical insurance when they are first eligible, unless they elect not to have the coverage. Accordingly, under your committee's bill, the aged and the disabled would be automatically enrolled for supplementary medical insurance as they become entitled to hospital insurance. Persons already receiving monthly social security or railroad retirement benefits would be deemed to have enrolled in the month before the month for which they become entitled to hospital insurance, so that their medical and hospital insurance coverage will start at the same time. Others, not already on the cash benefit rolls, would be deemed to have enrolled for supplementary medical insurance in the month, in which they file an application establishing their entitlement to hospital insurance, and their coverage under medical insurance would begin at the time specified by existing law for people enrolling in that month.

Your committee expects that persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. They would be deemed to have enrolled if they do not decline coverage before it is scheduled to begin. Once their coverage has begun they would of course be free to dis-enroll if they wish in accordance with existing law.

The automatic enrollment provisions would be applicable only to persons who become entitled to hospital insurance after 1971, because of the practical difficulties that would be involved in locating nonenrollees whose eligibility for medical insurance was established prior to 1972 and giving them an opportunity to decline the coverage.

(g) Establishment of incentives for States to emphasize comprehensive health care under medicaid programs.-- Your committee has been concerned about the need to improve the utilization of services under the medicaid program and to encourage more effective lower cost patterns of service. The present law has a uniform Federal matching percentage applied to all forms of health services covered under the State medicaid plan. In order to encourage the States to make more efficient use of health services, your committee's bill would create incentives for States to contract with health maintenance organizations or similar organizations an disincentives to discourage prolonged stays in institutional settings. Specifically, the bill would provide for (1) an increase of 25% (up to a maximum of 95%) in the Federal medicaid assistance matching for amounts paid by States under contracts with health maintenance organizations of other comprehensive health care facilities; (2) a decrease in the Federal medical assistance percentage by one-third after the first 60 days of care (in a fiscal year) in a general or tuberculosis hospital; (3) a reduction in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a skilled nursing home unless the State makes a showing satisfactory to the Secretary that there is in the State an effective program of controls over utilization of such institutional care, (4) a decrease in Federal matching by one-third after 90 days of care except that an additional 30 days care would be allowed if the State shows that the patient will benefit from such additional period of hospitalization in a mental hospital and provision for no Federal matching after a total ***5059** of 365 days of such care during an individual's lifetime, and (5) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

These changes would be effective with respect to services furnished after June 30, 1971, except that the provision relating to the computation of a reasonable cost differential between skilled nursing homes and intermediate care facilities would be effective for any calendar quarter beginning after December 31, 1971.

The proposal to increase by 25 percent, up to a maximum of 95 percent, Federal matching on premiums paid by states under contracts with health maintenance organizations, neighborhood and community health centers and similar organizations is intended to encourage states to contract with such organizations. Organized plans, particularly those on a pre-paid basis, have been shown in some cases to discourage overutilization of expensive inpatient care.

The limitations on care in general and tuberculosis hospitals are designed to encourage transfer of patients to less expensive facilities. They reflect the assumption that treatment in acute institutions is generally of short duration, rarely exceeding 60 days.

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The proposed limitations on length of stay in mental institutions reflect the assumption that for patients over 65 medical treatment of mental disease inpatients generally does not exceed three months and rarely continues beyond a year. However, in those cases where the State agency demonstrates that the patient is continuing to receive active treatment and the prognosis is for further improvement the medicaid percentage would not be reduced until 120 days. This will provide needed flexibility under the basic provision.

The reduction in matching for skilled nursing homes is directed toward early transfer of patients to alternative facilities (such as intermediate care facilities). There is a good deal of evidence found by the General Accounting Office and by the HEW audit agency that patients now in skilled nursing homes in may States do not belong there. A lower level of care than skilled nursing care would suit the needs of a large number of these patients. In the 1967 **Social Security Amendments**, the Congress attempted to meet these kinds of problems by funding intermediate care facilities at the medicaid matching rate (so as to avoid any financial incentive to use the higher level of care) and by requiring regular professional independent medical audit of the needs of nursing patients. Some States have used the intermediate care facility as the less expensive option it was intended to be. Others have not used it all or have not used it effectively. Some few States have set up the required professional medical audits.

Your committee recommends a reduction in the Federal medicaid matching rate by one third after the 60th day of stay in a skilled nursing facility unless the State can show that it is carrying out an effective program under requirements for effective utilization review procedures and for regular professional medical audits. A State could maintain its full Federal share by complying with these necessary requirements. If it did not, the matching rate would be reduced with respect to stays. The 60 day period would provide an adequate period of time for the necessary review and certification requirements to be carried out.

***5060** The provision granting authority to the Secretary to compute (for reimbursement purposes) a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facilities is designed to assure that supporting care in these alternate institutions actually does result in decreased costs to the program.

(h) Cost-sharing under medicaid.-- Your committee has been concerned that costs of the medicaid program have been escalating much more rapidly than anticipated and believes that an element of cost consciousness on the part of patients and their physicians should be introduced into the program primarily as a cost control device. Your committee bill would, therefore, require that States participating in the medicaid program impose on the medically indigent (those not eligible for cash assistance) under the program a premium enrollment fee graduated by income in accordance with standards prescribed by the Secretary. No other premium or enrollment fee could be imposed on the medically needy under the State plan. In the case of cash assistance recipients, nominal deductible and cost-sharing charges, while prohibited with respect to mandatory services required under the plan, would be permitted with respect to optional services.

States could, at their option, impose deductibles and copayment features on the medically indigent (in addition to the required graduated premiums) which would not have to vary by level of income. Your committee recommends these provisions in order to discourage possible unnecessary overutilization and to encourage cost-consciousness on the part of those covered under medicaid.

(i) Elimination of medicaid work disincentive.-- Your committee bill would amend title XIX to assure that medicaid eligibility requirements for families with children are structured in a way which relates them to family income and medical expenses, removes work disincentives, and concentrates medical assistance resources on those families most in need.

The medicaid statute has from the beginning required those States which elect to have a medicaid program to cover everyone who was eligible for cash assistance payments. With the introduction of the earnings disregard provisions under the 1967 amendments, and the consequent gradual loss of cash benefits as earned income increased, families on the assistance rolls can have a substantial total income, and still receive full medicaid protection. The medicaid program has, therefore, a work disincentive effect at some point in the earnings scale-- the earning of an extra dollar can mean the phaseout of cash assistance, and the abrupt and complete loss of medicaid.

In the 24 States which had made no provision for covering the medically needy (the groups related to the welfare categories

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but with income in excess of the standard for public assistance), the loss of medicaid was complete. The family could not re-establish eligibility for medical assistance without dropping back on the public assistance rolls. In the 28 States and jurisdictions with programs for the medically needy, the situation was only slightly better. Since the maximum eligibility level for the medically needy was one hundred thirty three and one-third percent of the payment level (and the payment level was often below the cash assistance standard), this standard is in some of these States several thousand dollars below the income level where cash assistance phased out under the earnings disregard provisions. This meant that the family which had lost medicaid coverage with ***5061** their loss of cash assistance could re-establish their eligibility for medicaid only after incurring substantial medical expenses (equal to the amount by which their income exceeded the medically needy standard for families of that size).

Your committee proposes to correct these deficiencies by providing complete medicaid coverage to cash assistance families with children only if their income falls below the eligibility level established for medical assistance. In determining income for this purpose, the first $720 of earned income would be disregarded (this amount is allowed for work related expenses under the family program provisions in the bill).

The medical assistance eligibility level would be defined by the State in the range between the payment level for an eligible family of given size without income up to one-hundred thirty-three and one-third percent of that payment level. Cash assistance families with incomes above the eligibility level would receive medicaid coverage only after incurring medical expenses equal to the amount by which their total income (including cash assistance payments) exceeded the medicaid standard; they would be required to ‘spend down‘ by this amount to establish their eligibility for medicaid. In effect, this amount would be a deductible, increasing in amount as earnings rise and, therefore, avoiding the situation where one dollar of earnings can result in the loss of protection worth several hundred dollars. Medical expenses for this purpose would be defined as those in section 213 of the Internal Revenue Code.

Your committee does not propose to change medicaid eligibility for the adult categories except to allow a uniform amount of earnings in the amount of $720 ($1,020 for the blind and disabled) to be disregarded as work related expenses in determining income for purposes of medicaid eligibility. States would continue to have the option of operating programs for the medically needy for the aged, the blind, the disabled, foster children, families as defined in section 405(b), and all needy children under 21 who are not recipients of cash assistance.

Eligibility standards for the medically needy would be tied to the payment level for families under title XXI plus the supplementary payment, if any, provided by the State, with appropriate adjustments to account for family size. States with medical assistance eligibility levels higher than the payment level, but less than 133 1/3 percent of that level, would be required to provide medical assistance to all individuals, whether recipients of cash assistance or not, whose income, after deducting medical expenses falls below the medical assistance level. These latter changes are essentially those necessary to preserve the effects of present law.

The proposed amendment is estimated to result in a saving of approximately $140 million in Federal medicaid funds in the family category. This savings results from the elimination of some of the medical costs of cash assistance recipients who have earnings in excess of $720 (the amount allowed for work expenses).

The estimate was prepared on the assumption that States without current programs for the medically needy would set the eligibility level at their current payment standard or $2400, whichever was higher; and States with a current program for the medically needed would maintain the medicaid eligibility level at the current medically needy standard.

***5062** (j) Payment under the medicare program to individuals covered by Federal employees health benefits program.--Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over.

Part A hospital insurance protection under medicare is earned during a persons’s working years through a separate tax on his earnings and no payments are made by those entitled to benefits after they have stopped working. In contrast, persons who

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are eligible for health insurance protection under FEHB plan continue to pay the same premium rates for their coverage after retirement as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 40 percent of the overall cost of FEHB protection.

When the medicare program was enacted in 1965, it was intended that it would provide basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the protection provided under medicare rather than to duplicate the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits. It is true, however, that some individual plans have afforded more protection to those enrollees with medicare coverage than those without such coverage.

Although most Federal employment covered by a Federal staff retirement system is excluded from social security coverage, many Federal employees become insured under social security on the basis of other employment. About 50 percent of retired and active Federal employees age 65 and over are entitled to hospital insurance benefits under medicare.

Several problems arise under the present situation. The FEHB plans cover many of the same health care expenses that are covered under medicare. In cases where health care expenses are covered under both medicare and a Federal employee plan, the medicare benefits are paid first, and the Federal employee plan then pays its benefits in an amount which, when added to the benefits payable under medicare, may not exceed 100 percent of the expenses who is covered under a high-option FEHB plan.

A Federal employee who is covered under a high-option FEHB plan as well as the medicare plans has somewhat better protection than is afforded under the FEHB plan alone. But, because of the nonduplication clauses in the FEHB contracts, he does not derive the full value of the protection of the FEHB contracts. If a Federal retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

***5063** Federal retirees and employees who are covered under an FEHB plan generally do not find it advantageous to enroll in the medicare voluntary supplementary medical insurance plan, because of the overlapping of FEHB benefits and benefits under the supplementary plan. Thus, Federal retirees and employees do not receive the advantage, available to virtually all other persons age 65 and over, of the 50-percent Government contribution toward the cost of the protection under the supplementary medical insurance program.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, your committee's bill would provide that effective January 1, 1975, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under the FEHB plan in which the beneficiary to whom the service was provided is enrolled. This provision would not go into effect (or would be suspended, if already in effect) if the Secretary of Health, Education, and Welfare certifies that the FEHB program has been so modified as to assure (a) that there is available to Federal employees or retirees age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare and the protection of part B alone, and (2) that the Government is making a contribution toward the health insurance of all Federal employees or retirees age 65 and over which is at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans. Nor would this provision apply with respect to an individual plan if the Secretary of Health, Education, and Welfare certifies that such plan (1) has made available to its enrollees age 65 and over protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone, and (2) is making a contribution toward the health insurance of its enrollees age 65 and over which is at least equal to the contribution made by the Federal Government for high option coverage under Government-wide FEHB plans. The contribution, whether by the Federal Government or by the individual plan, could be in the form of a contribution toward the supplementary FEHB protection or a payment to or on behalf of the individual employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. The

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Secretary would, of course, prepare his certification on the basis of information he obtains from the Civil Service Commission about the characteristics and operations of each of the various plans as well as the Federal program as a whole. It is the hope and the intent of your committee that the Secretary will be able to make this certification for each of the plans under the FEHB program before January 1975.

(k) Payment under medicare for certain inpatient hospital and related physicians' services furnished outside the United States.-- Under present law, services furnished outside the United States are excluded from coverage, with the single exception that hospital insurance benefits are payable for emergency inpatient services provided in nearby foreign hospitals if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital to which he is admitted is closer to the place where the emergency arose or more accessible than the nearest United States hospital ***5064** that is adequately equipped and available for his treatment. Your committee is concerned that under present law border residents who find that the nearest hospital suited to their inpatient care needs is located outside the United States may not receive protection against the health costs they incur in using these nearest hospitals except in the indicated emergency situations.

Your committee's bill would include a provision which would expand medicare coverage of services outside the United States to take account of the special problems of border residents. Medicare benefits would be payable for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital approval program having essentially comparable standards would be covered.

The present provisions covering emergency inpatient hospital services outside the United States would be retained.

Payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States. Where the hospital elected to bill the medicare program it would be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary, as is now done with respect to emergency services furnished by a nonparticipating hospital which furnishes actual cost data. Where payment could not be made solely because the hospital did not elect to bill the program, benefits would be payable directly to the beneficiary on the basis of an itemized bill if he filed an acceptable application for reimbursement. Subject to the appropriate deductibles and coinsurance, the beneficiary would be reimbursed in an amount equal to 60 percent of the hospital's reasonable charges for 'routine services' in the room occupied by him or in semiprivate accommodations whichever is less, plus 80 percent of the hospital's reasonable charges for 'ancillary services,' or, if separate charges for routine and ancillary services are not made by the hospital, two-thirds of the hospital's total charges.

To assure that medicare beneficiaries would be adequately protected against other medically necessary health care costs they may incur while receiving covered foreign inpatient hospital care, your committee's bill would also provide for coverage under the medical insurance program of medically necessary physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services.

Payment for physicians' services would be limited to the period of time during which the individual is eligible to have payment made for the foreign hospital services he receives. Further, the Secretary would be authorized to establish, by regulations, reasonable limitations upon the amount of a foreign physician's charge that would be accepted as reimbursable under the medical insurance program. In recognition of the administrative difficulties that would arise in applying the assignment method of reimbursement to medical services furnished in other ***5065** countries, your committee's bill would provide that benefits for foreign physicians' and ambulance services would be payable only in accordance with the itemized bill method of reimbursement provided for under present law.

These provisions would apply to services furnished with respect to hospital admissions occurring after December 31, 1971.

2. Improvements in operating effectiveness

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(a) Limitation on Federal participation for capital expenditures.-- Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money is currently being expanded under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels. Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. Your committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, your committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 125 planning agencies are receiving Federal grants: 72 of such agencies are operational. It is estimated that 140 areawide planning agencies will be receiving grants by the end of June 1971 and that more than 90 such agencies will be operational.

To avoid the use of Federal funds to support unjustified capital expenditures and to support health facility and health services planning ***5066** activities in the various States, your committee's bill authorizes the Secretary of Health, Education, and Welfare to withhold or reduce reimbursements amounts to providers of services and health maintenance organizations under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of $100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) An adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level. The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationships between such agencies, either within States or across State lines.

These limitations would be effective with respect to obligations for capital expenditures incurred after June 30, 1972, or earlier, if requested by the State.

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(b) Report on plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy in the provision of health services.-- Under present law, institutional providers furnishing covered services to medicare beneficiaries are paid on the basis of the reasonable cost of such services. Payment on this basis, with retroactive corrective adjustments, is consistent with the long history of public and private third party agency reimbursement for institutional health care on a cost basis. However, as experience under the medicare, medicaid, maternal and child health, and other third party programs has clearly demonstrated there is little incentive to contain costs or to produce the services in the most efficient and effective manner.

Your committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive financial incentives, as well as the risk of possible loss inherent in that method, to plan, innovate and generally to manage effectively in order to achieve greater financial reward ***5067** for the provider as well as a lower total cost to the programs involved. Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set a provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. This difference could be expressed as the 'profit.' Of course, if the provider's costs turned out to be higher than the prospective rate, there would be a loss. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency.

However, your committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear for example that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement-- if their requests were met-- in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

In view of the far-ranging implications of such a change in the approach to reimbursement, your committee's bill provides for a period of experimentation under titles XVIII, XIX, and V with various alternative methods and techniques of prospective reimbursement. It is the intent of your committee that experimentation be conducted with a view to developing and evaluating methods and techniques that will stimulate providers through positive financial incentives to use their facilities and personnel more efficently, thereby reducing their own as well as program costs while maintaining or enhancing the quality of the health care provided.

The experiments and demonstration projects directed to be carried out under this provision are to be of sufficient scope and on a wide enough scale to give assurance that the results would obtain generally (but not so large or comprehensive as to commit the programs to any prospective payment system either locally or nationally). No experiment or demonstration project is to be undertaken by the Secretary until he consults with and takes into consideration the advice and recommendations of recognized specialists in the health care field ***5068** who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under your committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1973, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

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Although recognizing the promise and potential offered by prospective reimbursement your committee does not wish to preclude experimentation with other forms of reimbursement. Your committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Secretary of Health, Education, and Welfare to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such States, and alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings. Authority is also provided to make payments, on an experimental or demonstration project basis, to organizations and institutions which have the capability of providing comprehensive health care, mental health care, and ambulatory health care, for services which are not currently covered under titles V, XVIII, XIX, and which are incidental to services covered under the programs, if the inclusion of the additional services would, in the judgment of the Secretary, offer some prospect of resulting in more economical provision and more effective utilization of services for which payment may be made under such programs.

The bill would authorize experimentation with the use of areawide or community wide peer review, utilization review, and medical review mechanisms to determine whether they would help to assure that health services provided to beneficiaries conform to appropriate professional standards and that payment will be made only for medically necessary services that in each case are rendered in the most economical setting that is consistent with professionally recognized standards. Authority is also provided to experiment with the use of fixed price or performance incentive contracts to determine whether they would have the effect of inducing more effective, efficient, and economical performance by medicare intermediaries and carriers.

It is intended that benefit costs and administrative costs incurred under this section would be paid out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in reasonable proportion to the participation of medicare in the project. Medicaid and private funds would also be used proportionately when medicaid and private programs participate in the project. These provisions will be effective upon enactment of the bill.

Your committee is concerned about the difficulties some beneficiaries who need extended care and their physicians face as a result of the present title XVIII provision under which payment may be made for services furnished in an extended care facility only if the beneficiary was transferred from a hospital after a stay of at least three days. Therefore, in addition to the other experiments the Secretary will be ***5069** undertaking, your committee expects him to conduct studies and engage in experiments to determine the effects of eliminating the three-day prior hospitalization requirement, which he has authority to waive for the purpose of such experimentation, and report to your committee his findings together with any recommendations he may have for changes in this provision.

(c) Limitations on coverage of costs under medicare.-- Your committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. Your committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. Your committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the committee's view that if patients desire unusually expensive service they should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficiency in the delivery of needed care services the institution should not be

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shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority ***5070** to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The proposed new authority to set limits on costs recognized for certain classes of providers in various service areas differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis-- relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable-- so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made. Your committee expects that the provision will not be applicable where there is only one hospital in a community-- that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

Your committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And your committee recognizes that these provisions will apply to a relatively quite small number of institutions. The data that are available for this purpose will often be less than perfectly reliable-- for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year . Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care-- for example, the costs of the 'hotel' services (food and room costs) provided by hospitals-- ***5071** the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might

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establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity-- particularly relatively high personnel costs in relation to patient loads where occupancy rates are low-- in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. Your committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charged by such providers.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be made on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from $4 to $9 a day with a median cost of $5 a day and the limit for food services set by the Secretary for 1971 was $7.20 a day, the hospital previously experiencing costs of $9 a day could charge patients $1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from the payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

***5072** The provision would be effective with respect to accounting periods beginning after June 30, 1972.

(d) Limits on prevailing charge levels.-- Under present administrative policies under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be set at a level no higher than is necessary to embrace the 75th percentile of customary charges for that service in the physicians' locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250 and 5 percent rendered by physicians who charge $300 and with the remaining 5 percent rendered by physicians charging in excess of $300, the prevailing limit would be $250 since this is the level that would cover at least 75 percent of the cases.

Customary charges for services that are within the prevailing fee limit are generally recognized in full. (In a relatively small number of situations additional rules are used to judge the reasonableness of charges.)

Your committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

Under your committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1973 and in later years only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. What the bill provides is a limit on the increases that would be recognized on the basis of the other reasonable charge criteria. Increases in the customary charges of individual physicians and in the charges prevailing among physicians in a locality would continue to be recognized only on the basis of adequate evidence that such increases had been in effect for a period of time. The new ceiling on recognition of increases in prevailing charge limits that is provided would come into play only when the adjustments necessary to meet increases in the actual charges prevailing in a locality exceeded, in the aggregate, the level of increase justified by other changes in the economy.

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The Secretary would establish the statistical methods that would be used to make the calculations to establish the limit on the increases allowed by this provision.

The base for the proposed economic indexes would be calendar year 1970. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges that would be recognized in the fiscal year beginning after the end of that calendar year.

Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expense of practice and general earnings levels combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group. If, for example, available data indicated that for self-employed physicians as a group, expenses of practice absorbed approximately 40 percent of gross receipts of practice (the proportion indicated ***5073** by data compiled by IRS from tax returns), the Secretary could determine that the maximum aggregate increase in prevailing charge levels that could be recognized would be 40 percent of the increase in expenses of practice indicated by IRS data plus 60 percent of the increase in earnings levels indicated by social security data. Thus, if during calendar year 1971 the area increase in expenses of practice was 3 percent and the area increase in earnings was 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier in each locality during fiscal year 1973 would be 4.2. percent:

(.40 x .03) plus (.60 x .05) equals .042

The carrier would apply the prevailing charge criteria now in the law to data on charges in calendar year 1971 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1973. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling-- that is, if the new prevailing charge limits that were indicated for fiscal year 1973 by the 75th percentile of calendar year 1971 charges weighted in proportion to the representation of the related services in aggregate services in calendar year 1971 exceeded, in total, the prevailing charge limits indicated for fiscal year 1972 by the 75th percentile of calendar 1970 charges weighted in proportion to the representation of the related services in aggregate services in calendar year 1970 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1973 by the 75th percentile of calendar year 1971 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, your committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels and actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in operating expenses of physicians and in earnings, the rise in fees would be allowed in full.

Your committee believes it desirable to embody in the statute the limitations on medical charges recognized as prevailing now set forth ***5074** in medicare regulations under which no charge may be determined to be reasonable if it exceeds the prevailing charge recognized by the carrier and found acceptable to the Secretary for similar services in the same locality on December 31, 1970, or the prevailing charge level that on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year.

While tying the allowability of future increases in prevailing charges to general economic indicators is an appropriate method

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for reasonable charge determinations with respect to the services of physicians, your committee believes it would be inappropriate for reasonable charge determinations with respect to medical supplies, equipment, and services that do not generally vary in quality from one supplier to another.

This is so because no program purpose would be served by allowing charges in excess of the lowest levels at which supplies, equipment, or services can be readily obtained in a locality. For this reason, the committee bill permits deviation from generally applicable reasonable charge criteria where it is determined that medical supplies, equipment, and services do not generally vary in quality from one supplier to another.

Your committee recognizes that it will not be possible for the Secretary to immediately establish special charge or cost limits for every item or service not materially affected in quality by the supplier who actually furnishes it to the patient. However, the committee believes that it is important to make explicit the Secretary's authority and it is expected that he will assert such authority to impose rules for determining reasonable charges when, after due consideration, he determines that a particular item or service does not vary in quality from one supplier to another and devises special rules for reasonable charge determinations that he considers equitable and administratively feasible. Until the Secretary designates an item or service as falling within the scope of this provision and establishes rules for determining reasonable charges for that item, the presently applicable rules, including any special rules imposed by the carrier, would generally remain in effect.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs in fiscal year 1972 and thereafter may not be made with respect to any amount paid for items and services that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

The medicaid provisions of the **Social Security Amendments** of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually did set some type of limits of their own, typically less than usual or customary charges. The **Social Security Amendments** of 1967 added a new medicaid provision which required that a State plan must provide assurances that 'payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.' On June 30, 1969 HEW issued an interim regulation which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The HEW regulation stipulated that payments to providers would ***5075** be limited to those received in January 1969, unless payments were below the 75th percentile of customary charges. States whose payment structures provided fees above the 75th percentile of customary charges were required to adjust their payments so that they did not exceed reasonable charges as determined under medicare. The regulation also stipulates that after July 1, 1970, States may request permission to increase fees paid to individual practitioners only if two conditions are met:

(1) The average percentage increase requested above the 75th percentile of customary charges on January 1, 1969, may not exceed the percentage increase in the all-services component of the Customer Price Index (adjusted to exclude the medical component) or an alternative designed by the Secretary; and

(2) Evidence is clear that providers and the States have cooperatively established effective utilization review and quality control systems.

The proposed amendment is substantially along the lines of the present regulation.

(e) Limits on payment for skilled nursing home and intermediate care facility services.-- Your committee is concerned that costs for skilled nursing homes and intermediate care facilities have been escalating at a rate which is undesirable from the standpoint of Federal, State and local governments and the private sector. Your committee therefore recommends that limits be placed on Federal financial participation for costs of such facilities with a view toward exerting pressure on both the public and private sectors to limit further cost increases. The bill would provide that for any calendar quarter beginning after December 31, 1971, the average per diem cost for skilled nursing homes and intermediate care facilities countable for Federal financial participation be limited to 105 percent of such cost for the same quarter of the preceding year. However, in computing the per diem costs any amounts ascribable to increases in the Federal minimum wage, or other Federal law enacted after the enactment of the bill, would be disregarded.

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(f) Payments to health maintenance organizations.-- Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single capitation payment encompassing all covered services provided to medicare enrollees. Instead, medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related to the costs to the organization of providing specific services to beneficiaries, so that the financial incentives that such organizations have in their regular business to keep costs low and to control utilization of services do not carry over to their relationship with medicare.

Your committee believes that a serious problem in the present approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on what services are needed to provide more services, services that may not be essential, and even unnecessary services. A second major problem is that, ordinarily, the individual must largely find his own way among various types and ***5076** levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on. No one takes responsibility, in a large proportion of the cases, for determining the appropriate level of care in total and for seeing that such care, but no more, is supplied. The pattern of operation of health maintenance organizations that provide services on a per capita prepayment basis lends itself to a solution of both these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees regardless of the volume of services rendered, there is a financial incentive to control costs and to provide only the least expensive service that is appropriate and adequate for the enrollee's needs. Moreover, such organizations take responsibility for deciding which services the patient should receive and then seeing that those are the services he gets.

Your committee believes it would be desirable for medicare to relate itself to health maintenance organizations in a way that conforms more nearly to their usual way of doing business. The objective is to provide in the case of medicare beneficiaries, the same kind of financial incentives that health maintenance organizations have with respect to their other enrollees.

Accordingly, your committee's bill provides for medicare payment to such an organization with respect to beneficiaries enrolled with it to be made on a prospective per capita basis, encompassing all medicare covered services for which its enrollees are eligible to receive payment. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The payment would be determined annually in accordance with regulations of the Secretary at a rate equal to 95 percent of the estimated amount (with appropriate adjustments-- such as age and morbidity differentials-- to assure actuarial equivalence) that would be payable if such covered services were furnished outside of the framework of a health maintenance organization. For beneficiaries who are covered by both the hospital and medical insurance plans, payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds, with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization. The remainder of the payment would be made from the hospital insurance trust fund.

The 95 percent payment rate for any health maintenance organization would be based upon the reimbursement amount per capita for services furnished by other than health maintenance organizations, adjusted for variations in unit benefit cost due to service areas, reasonable availability of services, and underwriting rules. The service area concept encompasses the geographical locality where the health maintenance organization is providing the service, and in which there is a reasonable cross section of different types of institutions and practitioners and utilization rates. Where there is an abnormal scarcity of services or excessive services for persons not in the health maintenance organization in a particular locality, but the needs of health maintenance organization members are fully met, the actuarial equivalent cost would be determined by established actuarial methods which include the consideration of costs in comparable locations where the covered services are reasonably available. The actuarial ***5077** determinations should be performed by qualified actuaries experienced in health care program costing. This expertise also would be needed to appraise whether enrollment of poorer risks, such as institutionalized persons or persons of low income, were less than in proportion to the population in the service area and to determine the effects on costs. Similarly, special limitations of the health maintenance organization on access of members to care, and limitations on the provision of teaching and community services should also be taken into account in considering cost equivalence.

To guard against potentially excessive profits from the medicare payment your committee has included a provision to assure

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that the rate of retention gross revenues less costs for medicare enrollees would not be permitted to exceed the rate for other beneficiaries of the health maintenance organization. Since an acceptable rate of retention cannot be prospectively assured, the provision calls for an examination by the Secretary of the actual rates of retention experienced by the organization. The health maintenance organization would be required to submit to the Secretary, following each accounting period, a public accounting report which identifies (by amount and rate) the retention for all medicare beneficiaries, considered as a group, and the retention for all other enrollees of the organization, considered as a group. Any report showing a positive rate of retention for medicare enrollees which exceeds 90 percent of its rate for other enrollees would be subject to full audit. Where an excessive rate of retention is verified, the organization would be required to utilize such excess for additional benefits or reductions in premiums charged to medicare beneficiaries or to refund the excess to the trust funds.

For purposes of this provision, an 'excessive rate of retention' would ordinarily be any positive rate of retention for medicare enrollees which exceeds the organization's rate of retention for enrollees under age 65. However if persons over age 65 comprise more than one-half of the health maintenance organization's enrollment, an excessive rate of retention would be any rate with respect to its medicare enrollees which exceeds the rate of retention generally experienced by comparable types of organizations for enrollees under age 65. This latter provision is intended to assure that those organizations which are temporarily exempted from the requirement that one-half of the membership be under age 65 are nevertheless subject to a retention limit which accurately reflects the retention experienced by prepayment organizations which operate primarily in a true market situation.

Under this payment formula, the program is assured of saving for at least 5 percent over average payments made on behalf of medicare beneficiaries who are not enrolled in health maintenance organizations. More importantly, the payment mechanism rewards the health maintenance organization with earnings proportional to its efficiency relative to the traditional system and permits the especially efficient organization an opportunity to provide special incentives (in the form of additional benefits or premium reductions) for medicare beneficiaries to enroll and thus to maximize its returns.

The individuals with respect to whom such payment would be made are medicare beneficiaries who are entitled to both hospital insurance and supplementary medical insurance or to medical insurance only and who are enrolled with a health maintenance organization. They would receive medicare covered services only through the health maintenance organization, except for those emergency services as are furnished by ***5078** other physicians and providers of services. The health maintenance organization would be responsible for paying the costs of such emergency services. If an enrolled individual received nonemergency care through some other means than the health maintenance organization, he would have to meet the entire expense of such care, except in the case where a determination has been made that the individual received care outside the health maintenance organization which should have been furnished by the HMO.

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis; (2) all the services and benefits of both the hospital and medical insurance parts of the program; (3) physician's services, either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis. Since physicians play the major role in determining utilization of all covered services, such payment arrangement should contain an element of incentive for such physicians to assure that medicare patients are provided needed services in the most efficient and economical manner. (The group of physicians which has the arrangement with the health maintenance organization could, in turn, pay its physician members on any other basis, including fee for service.)

A health maintenance organization must have at least half of its enrolled membership under age 65 or be expected to meet this requirement within a period not exceeding 3 years with evidence or positive and continuing efforts to achieve the required enrollment distribution. The organization must also hold an annual open enrollment period during which it accepts enrollees on a nondiscriminatory basis up to the limits of its capacity. Additional requirements are: (1) that the organization furnish to the Secretary proof of its financial responsibility and its capacity to provide comprehensive health services, including institutional services, effectively and economically; (2) that the organization assure that the health services required by its enrollees are received promptly and appropriately and that they measure up to quality standards. The various elements of a health maintenance organization, such as the hospital, the extended care facility or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law.

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The Secretary would execute an individual contractual agreement with each qualified organization desiring to function as a health maintenance organization. Such contracts would be automatically renewed annually in the absence of reasonable advance notice by either party of intention to terminate at the end of the current term, except that the Secretary could terminate the contract at any time (after reasonable notice and opportunity for hearing) if he finds that the organization has failed substantially to carry out the contract, is carrying it out in a manner inconsistent with efficient, effective, and economical administration or no longer meets all requirements to qualify for payment as a health maintenance organization. Such contracts will include provisions giving the Secretary appropriate access to organization records to evaluate the quality of its performance with respect to provision of services as well as to determine compliance with fiscal requirements. In negotiating the contracts, the Secretary ***5079** may disregard other laws and regulations which impose conditions or restraints on the contractual process, but only where such conditions or restraints are inconsistent with the purposes of the medicare program.

Under this provision, your committee expects that the Secretary will issue regulations establishing means for effective implementation of an ongoing review program to assure that the health maintenance organization effectively fulfills beneficiary service needs by adhering to specified minimum requirements for full-time qualified medical staff, keeping beneficiaries fully informed on the extent of coverage of services received outside the organization, taking positive actions to assure that beneficiaries are not deprived of benefits through devices such as scheduling appointments at inconvenient times on unwarranted delay in scheduling of elective surgery, and avoiding discrimination against poor health risks through selective enrollment or poor service aimed at encouraging disenrollment of high users of services. The Secretary is also expected to take precautions against possible fiscal abuse of the program by examining (and, where required, taking exception to) any arrangement the health maintenance organization may have with providers, including related organizations, which appear to result in an unwarranted increase in costs or to overstate the value of any added coverage or reduction of premiums.

If the health maintenance organization provides only the services covered by the medicare program to its enrollees, the premiums it may charge its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program. If, however, the organization provides its enrollees services in addition to those covered under medicare, it must inform enrollees of the portion of the premium applicable to such additional services, and the portion applicable to medicare-covered services may not exceed the actuarial value of the cost-sharing provisions of the medicare program. These requirements are intended to assure that beneficiaries enrolled with health maintenance organizations benefit fully from their medicare coverage and are, in effect, charged no more than the deductible and coinsurance amounts. This provision will also assure that they are made aware of the exact cost of any coverage included in the benefits provided by the health maintenance organizations which is in addition to medicare coverage.

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organizations on benefit coverage would have the right to a hearing before the Secretary, in which the health organization would be an interested party, and to judicial review with respect to disputes involving amounts exceeding specified limits.

Beneficiaries could terminate their enrollment with a health maintenance organization and revert to regular coverage under the program in accordance with regulations. It is expected that, generally, disenrollment would take effect the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Your committee also notes that some potentially qualified health maintenance organizations currently have enrollees who may desire to continue membership in the organization but who do not wish to agree to receive covered services only from that organization. Since it would seem inequitable to require such individuals to either dis-enroll immediately ***5080** or involuntarily accept a limitation on their access to covered services, your committee has added a provision under which a health maintenance organization could continue through December 1974 to be reimbursed for covered care provided to beneficiaries who were members prior to January 1972 but who do not elect this option. Program payments in such cases would be determined on a per capita basis similar to that used for enrollees who elect the option, with appropriate payment reductions for out-of-plan use of covered services by such enrollees.

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The health maintenance organization provisions in the bill would be effective with respect to services furnished on or after January 1, 1972.

(g) Payment under medicare for services of physicians rendered at a teaching hospital.-- When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients-- that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee for service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patient of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for ***5081** private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts billed to other patients.

Your committee does not question the appropriateness of fee-for-service payment for physicians' services in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

Therefore, your committee's bill would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or 'equivalent cost' basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a

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reasonable ‘salary equivalency‘ basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital, or, where the number of full-time salaried physicians is minimal, at like institutions in the area. Your committee expects that any determination with respect to whether the size of a particular hospital’s salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed ***5082** medical staff time which would otherwise have to be obtained through employed staff on a reimbursable basis. Such funds would in general be made available on an appropriate legal basis to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital’s capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide ‘private patients.‘ This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians’ service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for follow up care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

Your committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient’s attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services. Furthermore, in some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and ***5083** the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if , for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution’s patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could,

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if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

Your committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Your committee's bill also provides that the law be amended so that a hospital could include the actual reasonable costs which an affiliated medical school incurs in paying physicians to provide patient care services to medicare patients in the hospital. The bill would also permit including in a hospital's reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. The hospital would be required to pay the reasonable cost of the services in question to the institution that bore the cost.

The above provisions would become effective with respect to accounting periods beginning on or after July 1, 1971.

(h) Advance approval of extended care and home health coverage under medicare.-- Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The post hospital home health benefit is payable on behalf of patients who, following hospitalization or an extended care facility stay, continue to require essentially the same type of nursing care on an intermittent basis, or physical or speech therapy. However, extended care facilities and home health agencies often care for patients who need less skilled and less medically oriented services in addition to patients requiring the level of care which is covered by the program.

***5084** Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for extended care facility or home health benefits cannot generally be made until some time after the services have been furnished. Your committee is aware that in result that the patient is faced with a large bill he expected would be paid or the facility or agency is faced with a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits that exists until after the care has been given tends to encourage physicians to either delay discharge from the hospital, where coverage may less likely be questioned, or to recommend a less desirable, though financially predictable, course of treatment. The aggregate effect is to reduce the value of the post-hospital extended care and home health benefits as a continuation of hospital care in a less intensive-- and less expensive-- setting as soon as it is medically feasible for the patient to be moved.

Your committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type of medical condition which ordinarily requires such care and that minimum coverage periods should be assured for such conditions. To achieve its purpose, your committee's bill authorizes the Secretary to establish by medical conditions and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits. These periods of presumed coverage would be limited to those conditions which program experience indicates are most appropriate for the extended care or home health level of services following hospitalization, taking into account such factors as length of hospital stay, degree of incapacity, medical history and other health factors affecting the type of services to be provided.

Your committee recognizes that, in order to avoid the risk of presuming coverage (by general medical category) in substantial numbers of cases where extended care or home health care may not be required, presumed coverage periods must necessarily

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be limited in duration and will not, in many cases, encompass the entire period that the patient will require covered care. Nevertheless, these minimum presumed periods will provide a dual advantage over the present system of coverage determination by (1) encouraging prompt transfer through assurance that the admission or start of care will be reimbursed and (2) identifying in advance the point at which further assessment should be made, on an individual case basis, of continuing need for extended or home health care. Where request for coverage beyond the initial presumed period, accompanied by appropriate supporting evidence, is submitted for timely advance consideration, it is expected that a decision to terminate extended care or home health coverage would ordinarily be effected on a prospective basis. For those conditions for which specific presumed periods cannot be established, current procedures for determining coverage would continue to apply; however, fiscal intermediaries should be able to make coverage determinations on a more timely basis for such admissions.

To prevent abuse of the advance approval procedure, intermediaries and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing ***5085** the patient's conditions or certifying patients' needs for posthospital extended care and home health services. The Secretary could suspend the applicability of the advance approval procedure for patient certified by physicians who are found to be unreliable in this respect.

This provision would be effective January 1, 1972.

(i) Authority of Secretary to terminate payments to suppliers of services.-- Present law does not provide authority for the Secretary to withhold future payments for services furnished by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although payment for past or current claims may be withheld on an individual basis where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information.

Your committee believes it important to protect the medicare, medicaid and maternal and child health programs and their beneficiaries from those suppliers of services who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services. Such protection is not now provided under the law. For example, if a physician is found guilty of fraud in connection with the furnishing of services to a medicare beneficiary, there is no authority under present law to bar payment on his subsequent claims so long as the physician remains legally authorized to practice. States can, and some do, bar from medicaid providers who abuse the program, but they are not now required to do so.

Under your committee's bill, the Secretary would be given authority to terminate or suspend payments under the medicare program for services rendered by any supplier of health and medical services found to be guilty of program abuses. The Secretary would make the names of such persons or organizations public so that beneficiaries would be informed about which suppliers cannot participate in the program. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there would be no Federal financial participation in any expenditure under the medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make medicare payments under this provision of the bill.

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). In addition, the entire program review team would review cases involving overcharging; however, only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

It is not expected that any large number of suppliers of health services will be suspended from the medicare program because of abuse. ***5086** However, the existence of the authority and its use in even a relatively few cases is expected to provide a substantial deterrent.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after

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enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished after June 30, 1971.

Any persons or organization dissatisfied with the Secretary's decision to terminate payments would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

It is not intended that this provision would in any way change the Secretary's present right to withhold payment where necessary payment information is not provided. Nor would the supplier of services be entitled to a hearing or judicial review with respect to payments withheld under such existing authority.

(j) Elimination of requirement that States move toward comprehensive medicaid programs.-- Section 1903(e) of the medicaid statute requires that each State make 'a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance.' Under an amendment adopted by the Congress in 1969 (Public Law 91-56, enacted August 9, 1969), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

Your committee has been concerned with the burden of the medicaid program on State finances and has included a provision in the bill which would remove section 1903(e) from the Act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

(k) Reductions in care and services under medicare program.-- Under current law (section 1902(d) amended by P.L. 91-56) a State cannot reduce its expenditures for the State share of medicaid from one year to the next. If a State wishes to modify its State plan so as to reduce the extent of care and services provided or to terminate any of its programs, the Governor must certify to the Secretary that (a) the State share of medicaid expenditures will not be reduced, b) the State is complying with the provisions in its plan relating to utilization and costs of services, and c) the modification is not made for the purpose of increasing the standard or other formula for determining payments.

Your committee is concerned with the effect of section 1902(d) on States which are faced with fiscal crises. Your committee is also concerned, however, that such crises should not operate to prevent the poor from receiving basic medical care and services, particularly the six specific services mandated by present law.

Your committee wishes to assure maintenance of effort with regard to the basic services-- physician, inpatient hospital, outpatient hospital, laboratory, x-ray and home health services, as well as nursing home care for those over 21 and early and periodic screening, diagnosis, treatment for those under 21. The bill would, therefore, amend ***5087** section 1902(d) by restricting the maintenance of effort requirement to these basic services. The State would be able to modify the scope and extent of optional services provided, such as drugs, dental care and eyeglasses. This would enable the States experiencing fiscal crises to respond to such crises without reducing their expenditures for those services most urgently needed by the poor.

(l) Determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs.-- Under present law, as defined in earlier regulations issued by the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. Several States have objected to this requirement, asserting that use of the medicare formula for medicaid reimbursement can result in their paying more than the actual cost of providing inpatient care to those eligible for medicaid. There is nothing in the legislative history which requires that reasonable costs should be defined precisely the same way for both programs, and there are reasons why they should not, such as the differing characteristics of the two populations served.

Your committee's bill would allow States to develop their own methods and standards for reimbursement, thereby giving them flexibility in working out satisfactory payment arrangements with their hospitals. The Secretary could disapprove a State's plan if it were shown to his satisfaction that the method developed by the State would not pay the actual and direct cost of providing care to medicaid eligibles. Reimbursement by the States would in no case exceed reasonable cost

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reimbursement as provided for under medicare.

Your committee bill wishes to make clear that it is not the intention of this section to shift the burden of costs from medicaid recipients to non-medicaid recipients. However, the States should not be unduly restricted in the methods with which they might experiment for payment of inpatient hospital services.

The bill would apply the same determination of reasonable costs to maternal and child health programs. The provisions would be effective July 1, 1972, or earlier if the State plan so provides.

(m) Amount of payments where customary charges for services furnished are less than reasonable cost.-- Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under services to individuals covered by these programs. This results, in some cases, in these programs paying higher amounts for services received by covered individuals than such individuals would be charged if they were not covered by these programs, because, in some cases, a provider's customary charges to the general public are set at a level which does not reflect the provider's full costs.

Your committee believes that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care-- for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and child health programs could not exceed the lesser of the reasonable cost of such services as determined ***5088** under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, your committee believes that it would be undesirable to apply this provision in the case of service furnished by public providers of services free of charge or at a nominal fee. The bill would provide, therefore, that where services are furnished by a public provider of services free of charge or at a nominal charge, the Secretary shall specify by regulation reimbursement based on those elements of costs generally allowed in the determination of reasonable cost that he finds will result in fair compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than the amount that would be paid under present law.

Your committee recognizes that a provider's charges may be lower than its costs in a given period as a result of miscalculation or special circumstances of limited duration, and it is not intended that providers should be penalized by such short-range discrepancies between costs and charges. Nor does the committee want to introduce any incentive for providers to set charges for the general public at a level substantially higher than estimated costs merely to avoid being penalized by this provision. Thus, your committee recognizes the desirability of permitting a provider that was reimbursed under the medicare, medicaid and child health programs on the basis of charges in a fiscal period to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.

Your committee intends that for purposes of administering this provision, 'customary charges' shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered to be the 'customary charge,' a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine medicare reimbursement.

The provisions relating to medicare would be effective with respect to services furnished by hospitals, extended care facilities and home health agencies in accounting periods beginning after June 30, 1971. Provisions relating to medicaid and maternal and child health would be effective for accounting periods beginning after June 30, 1971.

(n) Institutional planning under medicare.-- Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, your committee is aware of the fact that health care

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facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in the operations. The Advisory Committee on Hospital Effectiveness established by the Secretary of HEW in its report stated, ‘ * * * the fact must be faced that deficiencies in hospital management owe something, at least, to inattention, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital ***5089** trustee, or a hospital should be.‘ In recommending the requirement contained in the bill, the Secretary’s committee stated, ‘The requirement that detailed budgets and operating plans be prepared annually as a condition of approval for participation in Federal programs can be expected to disclose management inefficiencies in such health care institutions as a necessary first step toward bringing about needed improvements. Especially, the committee believes this requirement will compel the attention of many hospital trustees to lapses in management that would not be permitted in their own businesses.‘

Under your committee’s bill, providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals) would be required as a condition of participation under the medicare program, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan. The overall plan would be expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of $100,000 for acquisition of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and the proposed methods of financing such costs. It would have to be prepared under the direction of the governing body of the institution, by a committee consisting of representatives of that body, the administrative staff and the medical staff. The required annual operating budgets may be prepared by groupings of cost or income rather than a detailed itemization for each type of cost or income. The plan would cover the immediately following year and the immediately following 3-year accounting period and would be reviewed and updated annually to assure that it is consistent with the budgetary program of the provider.

The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

The new condition of participation would have to be met with respect to any provider of services for fiscal years of the provider beginning after the fifth month after the month of enactment.

(o) Payments to States under medicaid programs for installation and operation of claims processing and information retrieval systems.-- Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Federal matching is now set at 50 percent for administrative costs and 75 percent for compensation of professional medical personnel. Despite this requirement, many States do not have effective claims administration or well-designed information storage and retrieval systems; nor do they possess the financial and technical resources to develop them if required to do so by the Secretary.

Your committee proposes to aid the States in meeting their responsibilities by authorizing 90 percent Federal matching for the cost necessary to design, develop, and install mechanized claims processing and Federal Government acknowledges the obligation to provide technical assistance, including the development of model systems, to each State operating a medicaid program. It is expected that this financial and technical support will aid the States in realizing efficient and effective administration of the program, and that it will reduce program costs.

***5090** Your committee also recognizes the importance of this activity by providing in the bill for Federal matching funds at the 75 percent rate for the operation of the system approved by the Secretary.

States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. Experience with the medicare program indicates that the beneficiary complaints about discrepancies between the ‘explanation of benefits‘ form they receive, and the care actually provided, has been the largest single source of information on possible abuse and fraud. It is appropriate to combine the requirement that states provide such explanations with the increased Federal matching which would support such an activity. Savings resulting from improved administrative efficiency would more than offset the cost of this provision.

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This provision of the bill would be effective July 1, 1971.

(p) Prohibition against reassignment of claims to benefits.-- Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of HEW makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

Your committee's bill seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. It is not the intent of your committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

Your committee's bill would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

***5091** The provision would in no way interfere with the fiscal relationships between physician and hospitals, in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effectively July 1, 1972, or earlier if the State plan so provides.

(q) Utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs.-- Under present medicare law, each hospital and extended care facility is required to have a utilization review committee to review all long stay cases as well as review, on a sample or other basis, admissions, durations of stay and professional services. The reasons for requiring hospitals and extended care facilities to have utilization review committees for medicare cases apply with equal force to review of medicaid cases, but there is now no such requirement in the medicaid law.

Your committee's proposal would require hospitals and skilled nursing homes participating in the medicaid or maternal and child health program to have cases reviewed by the same utilization review committee already reviewing medicare cases or, if one does not exist by a committee which meets the standards established under medicare. States could, if they wish, impose more stringent requirements, e.g., they might request that the committee review medicaid patient stays earlier than medicare cases since the medicaid population is generally younger than that covered under medicare.

This provision would be effective July 1, 1972.

(r) Notification of unnecessary admission to a hospital or extended care facility under medicare.-- Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and the institution of its finding. No medicare payment is made for any services furnished after the third day following such notification.

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Your committee's bill would require a similar notification and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case where hospitalization or extended care is no longer necessary (or never was necessary), Thus, your committee's bill would remove the anomaly of continuing payment in a case where the utilization review committee determined in the course of sample or other review that admission to the institution or further stay was not necessary and would make parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision would be effective with respect to services furnished after the second month following enactment of the bill.

(s) Use of State health agency or other appropriate medical agency to perform certain functions under medicaid and maternal and child health programs.-- Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare program and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. Your committee believes that this duplication of effort in the verification ***5092** of and in the establishment and maintenance of health standards is unnecessary and inefficient and should be limited to the extent feasible. Your committee's bill would require the State to provide that the State health agency (or the State medical agency which licenses health facilities) shall perform these functions for medicare, medicaid, and the maternal and child health programs. Your committee would authorize the use of the appropriate State medical agency rather than limiting the designation to 'State health agency.'

Your committee also believes that the effectiveness and economy of the medicaid program would be enhanced through development of capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under-or-over-utilization of resources and the quality and appropriateness of care.

To encourage the development of the capabilities upon which these improvements would be based, your committee bill would provide that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective July 1, 1972.

(t) Relationship between medicaid and comprehensive health care programs.-- Present law provides that under Title XIX all eligible recipients should receive the same scope of services; that those services should be available throughout the States; and that recipients should have freedom of choice to determine where they shall receive their care. The law also provides that recipients may choose to obtain medical services from organizations providing them (or arranging for their availability on a prepayment basis).

These requirements for State plans, called 'comparability and 'statewideness ' have limited states in their ability to contract with organizations such as neighborhood health centers or pre-paid group practices to provide services to medicaid recipients. These organizations provide services which are often broader in scope than the services received under the medicaid plan, and, therefore, are not available throughout the State. Under current law States are able to contract with such organizations only (a) through a waiver under a provision in present law that the particular contract is a demonstration project, or (b) through establishing a separate premium rate for the particulars set of services offered under the State plan.

Organized plans, primarily those on a prepaid basis, have been shown to discourage overutilization of expensive inpatient care and to encourage less costly ambulatory care and preventive health measures.

Your committee bill would enable States to waive Federal statewideness and comparability requirements, if a State contracts with an organization which has agreed to provide health care and services in excess of the State plan to eligible people who reside in the geographic area served by such an organization, and who elect to obtain such care and services from such an organization. Payments to such organizations could not be higher on a per capita basis than per capita payments ***5093** expended for medicaid eligibles in the same general geographic area not under the proposed arrangement.

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The amendment would be effective upon enactment.

(u) Program for determing qualifications for certain health care personnel-- Under present law, the Secretary establishes various health and safety criteria as conditions for the participation of providers of service in the medicare program. In setting these standards it is necessary to establish criteria for judging the professional competency and qualifications of key personnel in these health facilities. Medicare and medicaid regulation have relied heavily on formal training courses and professional society memberships in judging professional competency.

Your committee agrees with the Secretary that appropriate criteria as prima facie evidence of competence are necessary. However, your committee is concerned that reliance solely on specific formal education or training, or membership in private professional organizations might serve to disqualify people whose work experience and training might make them equally or better qualified than those who meet the existing requirements. Your committee believes that failure to make the fullest use of competent health personnel is of particular concern because of the shortage of such personnel.

Your committee's bill, therefore, requires the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations. A proficiency testing program would help to make greater use of otherwise qualified health personnel and technicians who do not now meet medicare's formal criteria for judging professional competency and qualifications. Appropriate methods and procedures are capable of being promptly developed and applied to determine qualifications and to upgrade skills to qualifying levels.

Your committee obtained agreement from the Department last year to institute such a program with respect to clinical laboratory personnel and asked for a report on the matter by July 1, 1971. Your committee is looking forward to receiving that report.

The amendment would be effective upon enactment.

(v) Penalties for fraudulent acts and false reporting under medicare and medicaid.-- Under present law, a false statement or representation of a material fact in any application for payment under social security programs is defined as a misdemeanor and carries a penalty of up to one year of imprisonment, a fine of $1,000, or both.

Your committee believes that a specific provision defining acts subject to penalty under the medicare and medicaid programs should be included to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the medicare and medicaid programs. Thus, under the committee bill, the criminal penalty provision would include such practices as the soliciting, offering, or accepting or kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving providers of health care services. In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a persons' right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use. Under the bill, the penalty for such acts, as well as false statements or representations ***5094** of material facts in any application for payment under the medicare and medicaid programs, would be a fine of $10,000, 1 year of imprisonment, or both.

Continuing investigation and review of reports by the General Accounting Office have indicated that false statements may have been made by individuals and institutions with respect to health and safety conditions and operating conditions in health care facilities in order to secure approval for participation in the medicare and medicaid programs. While the numbers of different individuals and institutions involved in such fraud may not be large in relation to the number participating in the program, your committee believes that a specific penalty for such acts should be provided to deter the making or inducing of such statements. Thus, your committee's bill includes specific provisions under title XVIII (medicare) and under title XIX (medicaid) of the Social Security Act whereby anyone who knowingly and willfully makes, or induces or seeks to induce the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or agency in order to secure certification or approval to participate in the medicare and medicaid programs would be subject to imprisonment for up to 6 months, a fine not to exceed $2,000 or both.

These provisions would be in addition to and not in lieu of any other penalty provisions in State or Federal law.

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The amendment is effective upon enactment.

(w) Provider reimbursement review board.-- Under present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination. Although the HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, your committee believes that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement. This procedure would not apply to questions of coverage or disputes involving individual beneficiary claims.

Your committee's bill, therefore, provides for the establishment of a Provider Reimbursement Review Board. The Board would be composed of 5 members, knowledgeable in the field of cost reimbursement appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board would have to be a certified public accountant, and two members would be representative of providers of services.

Any provider of services which has filed a timely cost report may appeal an adverse final decision of the final intermediary with respect to the period covered by such a report to the Board where the amount in controversy is $10,000 or more. The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination. Implementation of the intermediary's determinations would not be held in abeyance pending the Board's decision.

The provider would have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing; to be represented by counsel; to introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary; and to examine and cross-examine witnesses. Under your committee's bill, all decisions by the Board would have to be based upon the record made at such hearings, which may ***5095** include any evidence submitted by the Department. Such evidence would include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, the Provider Reimbursement Review Board may find in whole or in part for the provider or the Government (including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal.)

A decision of the Provider Reimbursement Review Board would be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies the Board's decision adversely to the provider. In any case where such reversal or modification occurs, the provider of services would have the right to obtain a review of such a decision by the United States District Court for the district in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedure Act, notwithstanding any other provision in section 205 of the Social Security Act.

The amendments made by this section would be effective with respect to accounting periods beginning after June 30, 1971.

3. Miscellaneous and technical provisions

(a) Physical therapy services and other therapy services under medicare.-- Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The limitations imposed under present law on the coverage of physical therapy have been a source of some difficulty. For example, it has been difficult to explain why physical therapy services cannot be furnished in the therapist's office, especially in cases where the latter is more accessible than the facility to which the beneficiary must travel to obtain the service.

Your committee's bill would include as covered services under the supplementary medical insurance program the services of a physical therapist in independent practice, when furnished in his office or in the patient's home (including a place of residence used as his home other than an institution which is primarily engaged in furnishing skilled health care services). These services would be furnished under such licensing and other conditions relating to health and safety as the Secretary

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may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment established by a physician which prescribes the amount, type, and duration of services to be furnished and setting out professional qualifications in addition to State licensure for the physical therapists participating under this provision. The bill would provide that the Secretary establish regulations governing other conditions under which the proposed services would be furnished. Your committee expects the Secretary to be guided by the conditions now in effect for providers of outpatient physical therapy services, taking into account the less elaborate facilities generally present in the office setting, but assuring that the ***5096** regulations provide for the availability of an adequate program of physical therapy services in the therapist's office.

With respect to present law as it covers physical therapy services furnished to an inpatient of a hospital or an extended care facility, there are a few cases where an inpatient exhausts his inpatient benefits and can continue to receive payment for the physical therapy treatment (as a covered expense under the supplementary medical insurance program) only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. Your committee's bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its outpatients. This would permit an inpatient of a participating hospital or extended care facility to continue to receive covered physical therapy services under the supplementary medical insurance program in those cases where he had exhausted his inpatient benefits through which physical therapy services were covered under the hospital insurance program or where he is otherwise ineligible for hospital impatient benefits.

Your committee is concerned over the increasing costs of physical therapy services and other therapy services furnished in hospitals and extended care facilities. Accordingly, the committee bill includes two provisions for controlling program expenditures for therapy services and services of other health related personnel and for preventing abuse:

(1) Total charges on which payment may be made in a calendar year with respect to an individual for physical therapy services furnished to him in practitioners' offices or his home by independently practicing physical therapists may not exceed $100 (such payment would be subject to the deductible and coinsurance provisions of the supplementary medical insurance program). Program reimbursement for the reasonable charges for the covered services would be made either to the beneficiary or, on assignment, directly to the physical therapist.

(2) With respect to physical, occupational, and speech therapy services, or the services of other health specialists, furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency or by others under arrangements with such providers or other organizations, payment for the reasonable cost of such services may not exceed an amount equal to the salary which would have been payable if the services had been performed in an employment relationship, plus the cost of such other expenses an individual not working as an employee might have, such as maintaining an office, travel-time and expense, and similar costs. Your committee expects that the Secretary will, in establishing the criteria for determining the reasonable cost of such services, consult with the professions directly affected and give thorough consideration to procedures used in other public and private plans that may be local, regional, or national in scope.

The provisions for covering additional physical therapy services under supplementary medical insurance would be effective for services furnished on or after January 1, 1972. The provisions relating to the coverage of outpatient physical therapy services furnished to inpatients of hospitals or extended care facilities would be effective on enactment of the bill. The provision relating to determining the reasonable cost of services of therapists and other health specialists would be effective with respect to accounting periods beginning on or after January 1, 1972.

***5097** (b) Coverage of supplies related to colostomies.-- Payment under medicare for the bags and straps used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often necessary in surgical treatment of cancer of the bowel) is not specifically authorized by the law. Medicare pays for these as surgical dressings, but does not pay for the irrigation equipment and supplies used in treating a colostomy condition. The provision would correct this inequity by providing specific coverage for colostomy bags and supplies directly related to colostomy care, as prosthetic devices.

This provision would be effective on enactment.

(c) Coverage of ptosis bars.-- Under medicare's supplementary medical insurance program, specific provision is made for the

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coverage of leg, arm, back, and neck braces, which includes a variety of devices used to support weak or deformed body members or to restrict motion in a diseased or injured part of the body. However, medicare does not pay for ptosis bars used to support the drooping eyelids of patients suffering from paralysis or atrophy of the muscles of the upper eyelid. Your committee's bill would cover these devices in the same way as other supportive devices or appliances. No payment would be made, of course, for eyeglasses to which such devices may be attached.

This provision would be effective on enactment.

(d) Inclusion under medicaid of care in intermediate care facilities.-- In order to provide a less costly institutional alternative to skilled nursing home care, the Congress approved in 1967 an amendment to Title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in 'intermediate care facilities.' The provision was intended to provide a means for appropriate placement of patients professionally determined to be in need of institutional care but not care at the skilled nursing home level.

The intermediate care benefit was not intended to cover care which was essentially residential or boarding home in nature. It was not intended to provide a refuge for substandard nursing homes which would not or could not meet medical standards. It was not intended as a placement device whereby States could reduce costs through homes to intermediate care without careful and independent medical review of each patient's health care needs.

Many thousands of patients are in skilled nursing homes who do not need that level of care, according to recent General Accounting Office and HEW audit reports. Thousands of those people are in skilled nursing homes because their States have not as yet established intermediate care programs.

Your committee has, therefore, included an amendment to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.

Your committee's amendment is designed to make it clear that intermediate care coverage is for persons who require care in the entire range from just above simple boarding home arrangements up to, but not including the skilled nursing home.

Your committee amendment would require an intermediate care facility to meet such standards, prescribed by the Secretary, as are deemed necessary to assist in meeting the needs of the types of patients ***5098** expected to be placed in such institutions. The Secretary could establish several levels of standards depending upon the type of care involved. As indicated, the term intermediate care is a broad one encompassing institutions which are just above the boarding home level up to the institution which has a level of health care just below that of the skilled nursing home.

The amendment would provide for the transfer of the intermediate care provisions from Title XI of the Social Security Act to Title XIX (Medicaid). This action will enable the medically indigent, presently ineligible for intermediate care, to receive such care, when a State has a medically needy program and when such care has been determined as appropriate to their health care needs. This change should also serve to end the practice in some States of keeping medically indigent patients in skilled nursing homes when they could more appropriately be cared for in intermediate care facilities. Such States may do so because, under present law, Federal matching funds are available toward the costs of skilled nursing home care provided medically indigent persons but not for care of such people in intermediate care facilities.

Your committee's amendment would also authorize Federal matching under medicaid for care of the mentally retarded in public institutions which have a primary purpose of providing health or rehabilitation services and which are classified as intermediate care facilities. Matching would be available only in a properly qualified institution meeting standards (in addition to those required of an intermediate care facility) established by the Department for mentally retarded persons receiving an active program of health-related treatment or rehabilitation. States would not be eligible for the additional Federal matching funds unless they maintained present levels of State and local funds expended for care of the mentally retarded. The purpose here it to improve medical care and treatment of the needy mentally retarded rather than to simply substitute Federal dollars for State dollars. The provision would not provide Federal participation in payments to institutions that are primarily residential or custodial in character even though these may provide some health or rehabilitation services.

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Intermediate care would, under another provision in the bill by definition be less expensive than skilled nursing home care; therefore the cost of intermediate care should generally be significantly less than skilled nursing home care in the same area.

In view of the rapidly increasing expenditures for intermediate care and in view of the extension of intermediate care to the medically indigent, your committee has added another provision to its amendment requiring regular independent professional review of patients in those intermediate care facilities which have a significant health content. Teams headed by either a physician or a registered nurse would regularly review, on site, the nature of the care required and provided to each such intermediate care recipient. That review would be undertaken on a patient-by-patient basis and may not be performed at a distance or without reference to the specific circumstances of the individual patient. The Secretary of HEW would be expected to establish two or more levels of care encompassed under the intermediate care concept and then vary his regulations for such reviews based on the characteristics of the patients in the various levels of care.

***5099** The amendment would be effective January 1, 1972.

(e) Coverage prior to application for medical assistance.-- Under present law, a State may, at its own option cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying.

Your committee believes such coverage is reasonable and desirable. Your committee's bill would therefore require States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when services were received.

This provision would be effective July 1, 1972.

(f) Hospital admissions for dental services under medicare.-- Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

Your committee's bill would authorize the dentist who is caring for the patient to make the certification of the necessity for inpatient hospital admission for noncovered dental services under the above circumstances without requiring a corroborating certification by a physician. Your committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar with either the patient or the nature of the dental procedures to be performed.

This provision would be effective with respect to admissions occurring after the second month following enactment of the bill.

(g) Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.-- Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for nonpayment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

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***5100** Your committee's bill would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

(h) Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.-- Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

Your committee's bill would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

(i) Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.-- Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true.

Although rare, such cases may be a cause of considerable hardship and distress to the individuals involved, and present law permits no relief to be given. Your committee recognizes that enactment of the provision (discussed above) under which supplementary medical insurance enrollment would be automatic for individuals who are entitled to hospital insurance would in all likelihood result in a lesser number of problem cases involving supplementary medical insurance enrollment than are encountered under present law. However, since not all supplementary medical insurance enrollees will be entitled to hospital insurance and therefore will not be automatically enrolled for supplementary medical insurance, it is reasonable to expect there will continue to be such problem situations. It can also be expected ***5101** that some problem cases involving enrollment status may result form the automatic enrollment of eligible persons.

Your committee believes that where an individual's enrollment rights under supplementary medical insurance have been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program.

(j) Elimination of provisions preventing enrollment in supplementary medical insurance program more than 3 years after first opportunity.-- Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial

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enrollment period. A person whose enrollment has terminated may not enroll for the second time in supplementary medical insurance unless he does so in a general enrollment period which begins within 3 years after the effective date of such termination. An individual may reenroll only once.

The 3-year enrollment limit was included in the law (as are other limitations on enrollment in the supplementary medical insurance program) in the interest of avoiding antiselection in case the enrollment under the program was not a very substantial proportion of people eligible to enroll. For example, substantial numbers of people who are relatively healthy might delay enrollment until they are well past age 65 and have become sick, at which point they would enroll and receive substantial benefits without having paid much in premiums. However, since there is now a 95-percent rate of participation in the program and since the vast majority of enrollees enroll at the earliest possible time, there would seem to be no reason to retain the 3-year limit on enrollment. Further, present law provides that premiums for late enrollees are increased 10 percent for each full 12 months elapsed between the time they could have enrolled and actually do enroll and this provision would be retained. Such late-enrollment charges serve to prevent antiselection and to meet the higher costs associated with those who enroll at older ages. It is not intended, of course, that the months for which the law itself precluded individuals from enrolling or reenrolling would apply in determining the late-enrollment charges.

Your committee's bill would eliminate the 3-year limit with respect to both initial enrollment and re-enrollment after an initial termination. Enrollment periods would remain as presently defined and the restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all those who are ineligible to enroll because of the 3-year limit in effect under present law.

(k) Waiver of recovery of incorrect payments from survivor who is without fault under medicare-- Under present law, an individual to whom (or on behalf of whom) a medicare overpayment is made is subjected to recovery action with respect to such overpayment, ***5102** except that the recovery action may be waived if the individual is without fault and if recovery would defeat the purposes of the cash social security title (title II) of the Social Security Act, or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary against any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. If the latter situation, however, waiver of recovery action is not permitted even though the surviving beneficiary-- a widow, for example-- is without fault with respect to the overpayment.

The Social Security Amendment of 1967 included a provision which permitted recovery to be waived in the case of cash benefits if the individual from whom recovery is being considered is without fault, even though the overpaid individual was at fault. However, the comparable change with respect to medicare overpayments was not made. As a result, there are situations in which, for example, an overpayment made to a deceased beneficiary is the responsibility of his widow even though she was without fault in causing the overpayment, whereas if the overpayment had been made to or on behalf of the widow herself, the waiver provision would apply if she were not at fault.

Your committee's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purpose of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

(l) Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.-- Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving $5 and $10 claims for which the cost of holding a fair hearing has exceeded $100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than $100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

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Your committee's bill would require that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

(m) Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.-- Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either ***5103** the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enrollment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards-- one showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad beneficiaries who enroll with the Social Security Administration are not identified as applying to railroad beneficiaries because the beneficiary does not make this known, many railroad beneficiary claims are submitted to other carriers and require rerouting to Travelers Insurance Company. This is expensive and a cause of delay in making payments.

Your committee's bill provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law. Your committee's bill also provides that the Railroad Retirement Board shall contract with a carrier or carriers for purposes of servicing its beneficiaries with respect to part B benefits, an arrangement presently in effect as a result of the Commissioner of Social Security having delegated his authority to do this to the Railroad Retirement Board. Your committee expects the Railroad Retirement Board to make continuing efforts to assure that there is conformity between reasonable charges for covered services as these are determined by the carriers under contract with the Board and reasonable charges for comparable services in the same locality as these are determined by carriers acting for the Social Security Administration.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

(n) Prosthetic lenses furnished by optometrists under supplementary medical insurance program.-- Under present law, optometric services are not covered except with respect to services incidental to the fitting and supplying of prosthetic lenses ordered by a physician. Your committee's bill does not provide for any change in the present limitation on coverage of optometric services.

The committee believes, however, that the medicare requirement that a physician's prescription or order accompany requests for payment for covered prosthetic lenses when such lenses are furnished by an optometrist unduly limits both patient and optometrist and should be eliminated. The patient's freedom to choose either an ophthalmologist ***5104** or an optometrist to furnish him with prosthetic lenses should no longer be restricted by this requirement.

The committee bill would recognize the ability of an optometrist to determine a beneficiary's need for prosthetic lenses by amending the definition of the term 'physician' in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a 'physician' only for the purpose of attesting to the patient's need for prosthetic lenses. This change would not provide for coverage of services performed by optometrists other than those covered under present law.

The amendment would become effective upon enactment.

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(o) Prohibition against requiring professional social workers in extended care facilities under medicare.-- In order to participate as an extended care facility under the medicare program, institutions are now required to engage the services of a professional social worker. This requirement is not specified in the statute but was promulgated by the Secretary under his authority to establish conditions deemed necessary for the health and safety of patients. The regulation requires an extended care facility to designate one staff member to be responsible for attending to medically related social worker (that is, one who was graduated from a school of social work accredited by the Council on Social Work Education), the facility must have effective arrangements with a public or private agency (which may be a local welfare department) to provide social service consultation. In addition, a qualified social worker must participate in staff training programs, case conferences, and arrangements for staff orientation to community services to meet patient's needs.

Your committee recognizes and appreciates the value of medical social services, particularly for the medicare patient receiving extended care, since these services promote emotional and social adjustment of the patient and his family, aid rehabilitation, and contribute to effective discharge planning. However, the need to make such specialized services generally available from or under the direction of professional social workers can, in some cases, represent a substantial cost to the extended care facility which cannot be justified by the value derived by its total patient population. Your committee also notes that, although conditions for participation by hospitals include standards for a medical social service department, a hospital which does not have such a department may, nevertheless, be certified to participate in the program. It seems inconsistent with the medicare concept of movement of patients to progressively lower levels of care that provision of such a specialized ancillary service as medical social services would be optional for a hospital but required of an extended care facility.

While agreeing that services of professional social workers are appropriate for medicare reimbursement to those extended care facilities which provide them to their patients, your committee believes that the individual facility should have greater latitude in determining whether the medical social needs of its patient population require availability of professional assistance. Therefore, your committee's amendment would specify that provision of medical social services would not be required as a condition of participation as an extended care facility under the medicare program. Of course, where such ***5105** services are being provided it is expected that they would conform to recognized standards.

(p) Refunding of excess premiums under medicare.-- Under present law, where part B entitlement terminates due to the death of the enrollee, refund of any excess premiums is made, upon claims, to the legal representative of the enrollee's estate. If there is no legal representative and it is reasonably certain that none will be appointed, refund may be made, only upon claim, to a relative of the deceased on behalf of the estate.

It has come to the committee's attention that early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be the best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them to benefits subsequently payable on the same medicare claims number or to those relatives who would (except for age or dependency requirements) be eligible on the same record. However, the Office of General Counsel has advised that this could not be done in the absence of necessary authority in the law. Consequently, the much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

A similar problem is likely to exist with respect to premiums paid in advance under the provision of the bill which would provide, at a cost of $31 per month per enrollee, hospital insurance coverage for people who are age 65 and over and who are not eligible for such coverage under present law.

The committee bill, therefore, would provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated. This provision would be effective upon enactment.

(q) Waiver of requirement of registered professional nurses in skilled nursing homes in rural areas under medicaid program.-- Your committee is concerned that an undue hardship may be imposed on skilled nursing homes in rural areas through implementation of the medicaid requirement that all such facilities have an organized nursing service under the direction of a full-time professional registered nurse. In medicaid requirements due to the scarce supply of nursing of nursing personnel in

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such areas.

Your committee bill would therefore authorize waivers (for up to one year at a time and ending no later than December 31, 1975) of the requirements for skilled nursing homes in rural areas providing such homes make certain showings to the Secretary. Waivers would only be granted in those cases where (1) the nursing home is located in a rural area and the supply of other skilled nursing home services in such area is not sufficient to meet patient needs, (2) the failure of such home to qualify would seriously reduce the availability of services to beneficiaries in the area, (3) the nursing home has and is continuing to make a good faith effort to comply with this requirement but such compliance is impeded by the lack of qualified nursing personnel in such area, and (4) the requirements were met for a regular daytime shift.

Your committee wishes to assure that in no case will this provision result in the encouragement of substandard nursing services and that ***5106** every effort is being made by the facilities to comply with the nursing requirements.

(r) Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid.-- Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

Your committee believes that Christian Science sanatoriums, which do not actually provide medical care, should not be required to have a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would, therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator and other inappropriate medical requirements of the medicaid program. Such sanitariums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

(s) Requirements for nursing home administrators.-- Your committee is concerned that persons who have demonstrated their capability as nursing home administrators over a period of time should not be precluded from serving in this capacity because they fail to meet certain formal requirements imposed for purposes of the medicaid program. Your committee bill would, therefore, permit the States to establish a permanent waiver from such requirements for those persons who served as nursing home administrators for the three-year period preceding the year the State established a program for the licensing of nursing home administrators.

(t) Termination of National Advisory Council on Nursing Home Administration.-- The 1967 **Social Security Amendments** required State licensure of nursing home administrators. The statute also established the National Advisory Council on Nursing Home Administration in order to study, develop, and advise the Secretary and the States concerning matters relating to the qualifications, training and other areas related to a proper program of licensure. The Council was scheduled to terminate on December 31, 1971.

Your committee has noted that the Council has essentially completed its work and has passed a resolution to that effect. Therefore your Committee bill would provide for the termination of the National Advisory Council on Nursing Home Administration thirty days after enactment of this bill. It is expected that the Medical Assistance Advisory Council would assume responsibility for any continuing need for advice and assistance with respect to licensing of nursing home administrators.

(u) Increase in limitation on payments to Puerto Rico for medical assistance.-- Under present law, Federal matching funds for Puerto Rico's Medicaid expenditures are at the rate of 50 percent, except that the total amount of Federal funds may not exceed $20 million in any fiscal year.

Your committee believes that the $20 million Federal maximum on Medicaid payments to Puerto Rico should be adjusted to reflect the rise in hospital and health care costs, as well as the number of people eligible for Medicaid since 1967, when the ceiling and matching rate were established.

***5107** Your committee recognizes the effective improvement in the delivery of health care to the poor which has

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characterized the Puerto Rico Medicaid program and the fact that the cost of health care has substantially increased since 1967 when the original ceiling was established.

Your committee's bill would therefore provide that the Federal ceiling on title XIX payments to Puerto Rico be increased to $30 million effective with the fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged.

(v) Study of chiropractic coverage.-- Your committee's bill would require the Secretary to conduct a study of chiropractice services covered under State plans approved under title XIX. The objectives of the study would be to determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts to be paid for whatever services might be provided. The study would include one or more demonstration projects designed to assist in providing (under controlled conditions) the information necessary to achieve the objectives of the study. The Secretary would be required to report the results of the study to the Congress within 2 years after the date of enactment of this bill, together with his findings and recommendations based on the study, and on the information he obtains concerning the experience of public and private plans which now or did cover chiropractic services.

C. ACTUARIAL COST ESTIMATES UNDER THE BILL

1. FINANCING

Consistent with the policy of maintaining the social security program on a sound financial basis, which has been followed in the past, the bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the hospital insurance program will be considerably less than the costs of the program. To meet the cost of the expanded cash benefits and hospital insurance programs and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base-- the maximum amount of annual earnings subject to contributions and used in computing benefits-- would be increased.

(a) Increase in the contribution and benefit base.-- The proposed increase in the contribution and benefit base from $7,800 to $10,200 in 1972, rather than to $9,000 as provided in present law, would not only provide higher benefits at higher earnings levels, but also would help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of ***5108** earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing these higher benefits is less than the additional income from the combined employee and employer contributions on earnings above the former maximum and up to the new maximum amount.

(b) Changes in the contribution rates.-- Under the schedule of contribution rates for cash benefits that your committee recommends (shown below), the contribution rates for the cash benefits program for employers and employees for 1972 through 1974 would be decreased from the present 4.6 percent each, now scheduled for 1972, and 5 percent each, now scheduled for 1973 and 1974, to 4.2 percent each. For 1975, the rate would be 5 percent each, as now scheduled. For 1976 the rate would be decreased from 5.15 percent each, now scheduled in the law, to 5.0 percent each. For 1977 and after, the rate would be increased from 5.15 percent each to 6.1 percent each.

For the self-employed, the rate scheduled for 1972 for the cash benefits part of the program would be decreased from 6.9 percent to 6.3 percent. Thus the currently payable rate of 6.3 percent would remain in effect until 1975 at which time the increase to 7 percent, the highest rate scheduled under present law, would go into effect.

Your committee also recommends changes in the contribution rate schedule for the hospital insurance program. The contribution rate would be increased from 0.6 percent each for employees, employers, and the self-employed to 1.2 percent each beginning in 1972 and 1.3 percent each for 1977 and after. Under present law the rate is scheduled to increase gradually

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from the present 0.6 percent to 0.9 percent for 1987 and after.

CONTRIBUTION RATE SCHEDULES UNDER PRESENT PLAN AND H.R. 1

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(c) Change in allocation to the disability insurance trust fund.-- The bill would revise the allocation of contribution income to the disability insurance trust fund without significantly altering the long-range income of the fund. Under present law, 1.10 percent of taxable wages and ***5109** 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. Under the committee's bill, the allocation to the disability insurance trust fund would be as follows:

(In percent)

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The revision in the allocation is necessary because, under present law, the disability insurance trust fund grows slowly but steadily in the near future, according to the intermediate long-range cost estimate, until the year 2000. Thereafter it decreases slowly until exhaustion in the year 2019.

2. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) Summary of actuarial cost estimates

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill shows an actuarial balance of -0.06 percent of taxable payroll under the long-range cost estimate. This is, of course, close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows an actuarial balance of -0.02 percent of taxable payroll under the provisions of the bill. Accordingly, the disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) Financing policy

(1) Contribution rate schedule for old-age, survivors, and disability insurance in H.R. 1

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill, as to the combined employer-employee rate, is lower than that under present law by 0.8 percent in 1972, and by 1.6 percent in 1973-74, is the same in 1975, is lower by 0.3 percent in 1976 and higher by 1.9 percent in 1977 and after. The maximum earnings base to which these tax rates are applied is $10,200 per year for 1972 and after under your committee's ***5110** bill as compared with $9,000 under present law. These tax schedules are as follows:

(Percent)

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The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for your

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committee's bill, as compared with present law, are as follows:

(Percent)

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The corresponding allocated rates for the self-employed contribution rate are as follows:

(Percent)

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
It should be remembered that the workers and employees contribute a combined, rounded rate for the two programs (old-age, and survivors insurance and disability insurance), and not the above complex fractional rates separately. Such fractional rates are merely used by the Treasury department to divide up the aggregate tax receipts between the two trust funds.

The schedule of allocation rates for the disability insurance trust fund in your committee's bill has been obtained in the following manner. The combined employer-employee rates, rounded to the nearest 0.05 percent of taxable payroll, were determined for the short-range years that would produce the same relative accumulation of funds as in the Old-age and Survivors Insurance Trust Fund. The remainder of the schedule was calculated to produce, as close as possible, an exact actuarial balance on the basis of rates rounded to 0.05 percent of taxable payroll.

The self-employed tax allocation was determined by allocating to the Disability Insurance Trust Fund the same proportion of the self- ***5111** employed rate that was determined for the combined employer-employee rate with the condition that the allocation would not decrease in the future. The resulting rates were rounded to the nearest 0.005 percent of taxable payroll.

The allocation rates for the old-age and survivors insurance trust fund were obtained by merely and subtracting the allocation rates for the disability insurance trust fund from the appropriate total tax rates.

(2) Self-supporting nature of system

The Congress has always carefully considered the cost aspects of the old-age survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and thus actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with the individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of the present time, have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs over the long-range period considered in the actuarial valuation. Thus, the concept of 'unfunded accrued liability' does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is

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quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation. The additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust ***5112** fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the long-range cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age survivors, and disability insurance system shows any significant actuarial insufficiency. Since 1965 (when the cost estimates were first made on a 75-year basis), the view has been held that, if such actuarial insufficiency has been no greater than 0.10 percent of payroll, it is at the point where it is within the limits of permissible variation.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in close conformity with these financing principles.

(c) Basic assumptions for cost estimates

(1) General basis for long-range cost estimates

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and slow but steady growth of the benefit roll. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

In the past, long-range estimates have been presented on a range basis to indicate possible variation in future cost. However, the intermediate cost estimates, which represented a dollar average of the high-cost and low-cost estimates, was used to determine the actuarial soundness of the program. In this report only the intermediate cost estimate is presented (shown for 1980 and after). This estimate is based on assumptions that are intended to represent close to full employment (4.0 percent unemployment) with average annual earnings at about the level prevailing in 1971. The use of 1971 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1972, the aggregate amount of earnings taxable under the program with the proposed $10,200 earnings base is estimated at $531 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with both prior and subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2015, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year ***5113** 2000 is by no means a typical ultimate year insofar as costs are concerned.

(2) Measurement of costs in relation to taxable payroll

In general, the costs are shown as percentages of taxable payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system

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but also, and to a greater extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has an average monthly wage of $300. Under your committee's bill such an individual would have a primary insurance amount of $169.00. If his earnings should have been 100 percent higher (i.e., yielding an average monthly wage of $600), his primary insurance amount would be $271.10. Under these conditions, the contributions payable with respect to his earnings would increase by 100 percent, but his benefit rate would increase by only 60 percent. Or to put it another way, when the earnings rate is lower, his primary insurance amount represented 56.3 percent of average monthly wage, whereas, when his earnings rate is higher, his primary insurance amount relative to his average monthly wage is 45.2 percent.

(3) General basis for short-range cost estimates

In the short-range cost estimates (shown for the individual years 1971-75) a gradual rise in the earnings level in the future (about 6 percent per year), close to what has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

Except for the effect of the automatic adjustment provisions the cost estimates have, in general, been prepared on the basis of the same assumptions and methodology as those contained in the 1971 Annual Report of the Board of Trustees.

(4) Level cost concept

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which amounts to 1 year's disbursements), based on discounting at interest and taking into account the present fund on hand. If such a level rate were adopted, relatively large accumulations in the trust funds would result, and in consequence there would be a sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) Future earnings assumptions

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels estimated to be experienced in 1971. This does not mean covered payrolls are assumed to be the same each ***5114** year; rather, they will rise steadily as the covered population at the working ages is estimated to increase. However, it is believed that in the future as earnings increase enough additional contributions would be obtained to finance the increases in the benefit that according to the consumer price index would be indicated by the automatic adjustment provisions, if at the same time the maximum taxable earnings base is adjusted according to increases in covered wages as indicated by the provisions.

It should be noted that estimated 1971 earnings levels are used in the long-range cost estimates, even though the experience for the year is not yet completed. It is believed that this is appropriate procedure for evaluating costs when proposed benefit increases become effective after the current year.

The automatic benefit increase provisions are designed as a backup to specific legislated increases to assure that rises in the cost of living will not, over a period of time, reduce the purchasing power of social security benefits. Definite estimates of the long-range dollar costs of these automatic benefit increases is not possible at the present time. However, these increases could be financed over the long-range future without any adjustment in the scheduled contribution rates if wages should increase in the future about twice as fast as the consumer price index and the maximum taxable earnings bases is adjusted periodically as provided in the automatic adjustment provisions in the bill.

(6) Interrelationship with railroad retirement system

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An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service and also for all survivor cases.

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that, over the long range, the net effect of these provisions will be a small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

(7) Reimbursement for costs of pre-1957 military service wage credits

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. These financing provisions were modified by the 1965 amendments. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the law. These reimbursements are intended to be made on the basis of a constant ***5115** annual amount (as determined by the Secretary of Health, Education, and Welfare) for each trust fund payable over the period up to the year 2015 (with such amount subject to adjustment every 5 years).

(8) Reimbursement for costs of additional post-1956 military service wage credits

Under your committee's bill, individuals in active military service during 1957-67 will receive additional wage credits in excess of their cash pay (but within the maximum creditable earnings base) in recognition of their remuneration that is payable in kind (e.g., quarters and meals). These additional credits are at the rate of $300 per quarter. (Similar credits for military service after 1967 are provided in present law-- as a result of the 1967 amendments.) The additional costs that arise from these credits are to be financed from general revenues on an 'actual disbursements cost' basis, with reimbursement to the trust funds on as prompt a basis as possible (and with interest adjustments to make up for any delay due to the time needed to make the necessary actuarial calculations from sample data and for the necessary appropriations to be made).

In many instances, the availability of these additional wage credits will not result in additional benefits because the individual will have maximum credited earnings without them or because the year in which such credits are granted will be a drop-out year in the computation of his average monthly wage. In the immediate-future years, the cost of these additional credits to the general fund will be relatively small (only about $39 million a year) since there will be relatively few cases arising, almost all due to death and disability.

(d) Actuarial balance of program in past years

(1) Actuarial balance of program after enactment of 1969 act

According to the cost estimates for the 1967 act made in 1969, there was a very favorable actuarial balance for the combined old-age survivors, and disability insurance system, but there was a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

The 1969 amendments increased benefits by 15 percent and the minimum benefit to $64 per month. These changes fully exhausted the previous actuarial surplus and the system was then in close actuarial balance. A reallocation of contribution to the disability insurance portion was necessary to place that program in close actuarial balance.

In 1970, the cost estimates for the old-age, survivors, and disability insurance system were completely revised. The new estimates showed significantly lower cost for both the old-age and survivors insurance portion and the disability insurance

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portion. The lower costs resulted from : (1) 1970 earnings level, instead of 1969 level; (2) an interest rate of 5 1/4 percent, instead of 4 3/4 percent; and higher labor-force participation rates for women. The new actuarial surpluses were then estimated at 0.29 percent of taxable payroll for the old-age and survivors portion and 0.05 percent of taxable payroll for the disability portion.

***5116** (2) Actuarial balance after Public Law 92-5

The social security changes in P.L. 92-5 approved in March 1971 contained a 10% benefit increase, which was guaranteed to all future as well as present beneficiaries, an increase in the maximum taxable earnings base to $9,000, and an increase in the ultimate contribution rate. After these changes the program was in close actuarial balance. The old-age and survivors insurance portion had a small deficit of 0.06 percent of taxable payroll, while the disability insurance portion had a deficit of 0.04 percent of taxable payroll, both of which are within acceptable limits of variation.

(e) Actuarial balance under the committee bill

Table I traces through the changes in the actuarial balance of the system from its situation under present law, according to the latest estimates, to that under the committee bill, by type of change involved.

TABLE I.-CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, LONG-RANGE COST, ESTIMATE, PRESENT LAW AND H.R. 1

(In percent)

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The changes made by your committee's bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of -0.08 percent of taxable payroll is inside the established limit within which the system is considered substantially in actuarial balance (i.e. -0.10 percent of taxable payroll).

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise ***5117** under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(f) Level-costs of benefit payments, by type

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the present law, according to the latest intermediate-cost estimate, is 9.22 percent of taxable payroll, and the corresponding figure for the program as it would be modified by your committee's bill is 10.33 percent. The corresponding figures for the disability benefits are 1.15 percent for present law and 1.23 percent for your committee's bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE II.-ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

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SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL, [3] BY TYPE OF BENEFIT

(Percent)

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(g) Short-range estimates of old-age and survivors insurance and disability insurance trust fund operations

SHORT RANGE ESTIMATES OF OASI AND DI TRUST FUND OPERATIONS

The short-range estimates under the committee bill take into account the effect of the provisions relating to automatic increases in benefits, the contribution and benefit base, and the annual exempt amount under the retirement test; a general benefit increase of 3% is assumed to become effective for January 1974; the contribution and benefit base is assumed to increase to $10,800 and the exempt amount under the retirement test to $2,160, effective January 1, 1974.

***5118** Contribution income for the old-age, survivors and disability insurance program in calendar year 1972 under the committee bill is estimated at $43.3 billion, about $2.1 billion lower than under present law. Benefit payments amount to $41.3 billion, an increase of $2.3 billion over present law. Assets of the trust funds will increase $2.7 billion in 1972 under the system as modified by the bill (Table III).

Under the program as modified by the committee bill, the old-age and survivors insurance trust fund will increase by about $2 billion in each of the years 1972-74. Then, in 1975, when the employee-employer contribution rate increases from 3.75 percent each to 4.475 percent each, the trust fund is estimated to increase by about $11 billion. Assets of the fund at the end of 1975 are estimated to total $52 billion. Large increases in the trust fund will also occur for an extended period thereafter (Table IV).

The disability insurance trust fund is estimated to increase by about $0.7 billion in each of the years 1972-74. Then, in 1975, when the employer-employee contribution rate allocated to this fund increases from 0.45 percent each to 0.525 percent each, the trust fund will increase by an estimated $1.6 billion. Assets of this fund at the end of 1975 will total about $10.4 billion. Relatively large increases in this fund will also occur for an extended period after 1975 (Table V).

TABLE III.-PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS, COMBINED, SHORT-RANGE ESTIMATE

(In millions)

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***5119** TABLE IV.-PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

(In millions)

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TABLE V.-PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

(In millions)

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***5120** (h) Long-range estimates of the old-age and survivors insurance and the disability insurance trust fund operations

Table VI gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption earnings remaining at their 1971 level and disregarding the effect of the automatic adjustment provisions) since nearly all of the populations concerned-- both covered workers and beneficiaries-- are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1970 for the next 20 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the long-range cost estimate, reaching $81 billion in 1980 and about $232 billion at the end of this century. The trust fund is shown as being exhausted in about 65 years, which results from the small lack of actuarial balance, as indicated previously.

TABLE VI.-PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 1, LONG-RANGE COST ESTIMATE

(In millions of dollars)

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The disability insurance trust fund, under the program as it would be changed by your committee's bill, would grow for many years after 1970, according to the long-range cost estimate, as shown by table VII. In 1980, it is shown as being $15 billion, while in 1990, the corresponding figure is $27 billion. There is a small excess of contribution income over benefit disbursements for every year after 1970 for the next 20 years.

***5121** TABLE VII.-PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 1

LONG-RANGE COST ESTIMATE

(In millions of dollars)

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Table VIII shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs.

TABLE VIII.-ESTIMATED COST OF BENEFIT PAYMENTS OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL, [4] UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL

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3. ACTUAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) Extension of the HI system to the disabled

The most important change in the hospital insurance system provided for in your committee's bill is the extension of the

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system to disabled workers under 65 who have been entitled to benefits under the disability insurance system for no less than 24 months; and to disabled widows and dependent widowers, and to beneficiaries entitled to child's benefits based on disability which began prior to 22, who have been entitled to cash benefits for no less than 24 months.

Estimating the costs for hospitalization and related benefits for a disabled population is more difficult than estimating the costs for similar benefits for those age 65 and over. This is so because the hospital insurance system with respect to the disabled is newly established, with no past operating experience, and because patterns of utilization for those long disabled are unclear.

***5122** However, your committee believes that the present cost estimates, which provide for hospital utilization rates for the covered disabled population which are three times the utilization rates for those over 65, and which are consistent in other respects to the cost estimates for the aged, are based on reasonable assumptions as to all forseeable factors. The resulting level cost over the 25 year valuation period is 0.46% of taxable payroll under the given assumptions.

(b) Change in copayment after 30 days and lengthening of the lifetime reserve

Two other changes in the hospital insurance system in your committee's bill are, from a cost viewpoint, of the same approximate magnitude but offsetting in nature.

The introduction of a copayment provision equal to one-eighth of the hospital insurance deductible which is applicable from the 31st through the 60th day of hospitalization, decreases the cost of the program by 0.02% of taxable payroll. The increase in the number of lifetime reserve days beyond the first 90 days of hospitalization from 60 days to 120 days increases the program cost by 0.02% of taxable payroll. The offsetting nature of these two provisions produces a negligible effect on the cost of the system.

(c) Summary of actuarial cost estimates and other changes in committee bill

The hospital insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is in long range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program has only a few years of operating experience, but also because of the less predictability of the variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the present cost estimates are made under reasonable assumptions with respect to all foreseeable factors.

Your committee's bill contains a number of provisions which are intended to reduce the cost of the program. Among these provisions are the elimination of payments to certain providers of services who have abused the program, the limitation of the payments to certain providers of services who furnish services which are determined to be unduly expensive, or unnecessary for efficient delivery of health services, certain limitations on financial participation for supporting unnecessary capital expenditures, the possibility of increased economy under prospective-reimbursement experiments and demonstration projects, the limitation of reimbursement to customary charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. The actuaries have not found it possible to estimate the extent of these savings; accordingly, any savings resulting from these provisions represents a safety margin in the cost estimate.

Your committee's bill also contains a provision that would eliminate payments under the medicare program for services covered by the Federal Employees Health Benefits plan, beginning in 1975, unless ***5123** such plan is modified to make available coverage supplementary to that under the medicare program. For the purposes of the actuarial cost estimates, no account is taken of any possible reduction in benefit payments under the medicare program on this account, because of the likelihood that such modification will occur.

The bill provides an opportunity for persons who are not otherwise eligible under the hospital insurance program to enroll, on a voluntary basis, and then to pay the estimated full cost of the benefit protection thus made available. Such voluntary elective individual coverage can also be obtained by States and other organizations on a group basis for their retired

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employees aged 65 and over who are not otherwise protected under the hospital insurance program.

In this area also, the actuarial cost estimates presented in this report do not take into account the effect of this provision for voluntary coverage of otherwise ineligible persons, since if the premium rate, which has been actuarially estimated at $31 per month for the initial period from January through 1972, proves to cover the cost of these individuals, there will be no net effect on the financial operations of the total program.

Another change made by the bill is to revise the reimbursement mechanism applicable to covered services for individuals who obtain their medicare coverage through a health maintenance organization (HMO). In such instances, the medicare program would pay for such coverage on a prospective capitation basis. The prospective per capita rates for both hospital insurance and supplementary medical insurance would be determined by using established actuarial methods. Each such rate of payment would be determined annually in accordance with regulations and would be equal to 95 percent of the amount (with appropriate adjustment to assure actuarial equivalence) that would be payable for covered services furnished by other than health maintenance organizations in the same geographical area. In order to assure that HMO'S have incentives to provide effective, efficient, and economical services to medicare enrollees, the rate of retention attributable to medicare enrollees is limited to the rate of retention with respect to all other individuals enrolled in the HMO. The amount of retention due to an excessive rate would be repaid by the HMO unless it is used to provide benefits for or to reduce the premiums charged medicare enrollees.

No valid experience under the medicare program is available for the purpose of making any cost estimates of the effect of the health maintenance organization provision.

In the early years of operation, however, there might be increased program costs, because the relatively few organizations of this type now in existence are being reimbursed only their actual costs, whereas under the provisions of the committee bill, they could, in the future, be reimbursed somewhat more than costs. On the other hand, if such organizations can provide medicare coverage at a lower cost than what would otherwise prevail, then in the future, if more of these organizations are formed, there might be net savings to the program. Accordingly, the actuarial cost estimates have not been increased to reflect the possible short-range cost aspects of this provision for a different reimbursement basis for health maintenance organizations since it is possible that in the long run the provision will result in savings.

***5124** (d) Financing policy

(1) Financing basis of committee bill

The contribution schedule contained in your committee's bill for the hospital insurance program under a $10,200 taxable earnings base beginning in 1972 (and subject to the automatic provisions thereafter) is as follows, as compared with that of present law:

(In percent)

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These increases in contribution rates, along with the additional income from the higher earnings base, will finance the additional benefits for the disabled, and at the same time, eliminate most of the actuarial deficit in the hospital insurance system which has developed since the present rates were enacted in 1967.

(2) Self-supporting nature of the system

Just as has always been the case in connection with the old-age survivors, and disability insurance system, your committee has very carefully considered the cost aspects of the present hospital insurance system and proposed changes therein. In the same manner, your committee believes that the hospital insurance program should be completely self-supporting from the contributions of employees, employers, and the self-employed (the transitional uninsured group covered by this program have their benefits and the related administrative expenses completely financed from general revenues). Accordingly, your

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committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, and thus actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the hospital insurance system is similar to that concept as it applies to the old-age survivors, and disability insurance system, but with the difference that cost estimates for the hospital insurance system are made over a period of 25 years in the future, rather than the 75 year period for the old-age, survivors, and disability insurance system. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit as compared to cash benefit.

Accordingly, it may be said that the hospital insurance system is actuarially sound if it is in substantial actuarial balance over a 25 year period. This will be the case if the estimated future income from ***5125** contributions and from interest earnings on the accumulated trust fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that results in the system being in balance or substantially close thereto. The financing changes provided in the committee bill are in close conformity with these principles.

(e) Hospitalization data and assumptions

(1) Past increases in hospital costs and in earnings

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1956 and through 1970.

TABLE A.-COMPARISON OF ANNUAL INCREASES IN HOSPITAL COSTS AND IN EARNINGS

(In percent)

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

(2) Effect on cost estimates of rising hospital costs

A major consideration in making cost estimates for hospital benefits, then, is how long and to what extent the tendency of hospital costs ***5126** to rise more rapidly than the general earnings level will continue in the future, and whether or not it may, in the long run, be counter-balanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly ‘catching up‘ with the general level of wages and obviously may be expected to ‘catch up‘ completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital

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services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that-- unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite-- an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly than the total earnings level, unless the earnings base is kept up to date.

For these reasons, the following cost estimates are based on the assumption that both hospital costs and wages will increase in the future for the entire 25 year period considered while at the same time the earnings base is assumed to increase to $10,200 in 1972 and to be kept up to date thereafter. The fact that the cost sharing provisions (the initial hospital deductible and the coinsurance features) are on a dynamic basis which varies with hospital costs is taken into account as not requiring a higher cost estimate than would be needed if static conditions were assumed.

(3) Assumptions as to relative trends of hospital costs per day and earnings underlying cost estimate for committee bill

The major consideration in making cost estimates for the hospital insurance program is how long and to what extent the tendency of hospital costs to rise more rapidly than the general earnings level will continue, or whether it may not in the long run be counterbalanced by a trend in the opposite direction.

The assumptions underlying the cost estimates for the committee bill are that costs of hospitalization will continue to rise faster than earnings in the near future, but that the cost-earnings differential reached its peak in 1969, and will gradually decrease and merge with the annual rate of increase in general wages by 1980. Specifically, the assumptions as to future rates of increase in average wages in covered ***5127** employment and in the average daily costs of hospitalization are shown in Table B.

TABLE B.-ASSUMPTIONS AS TO FUTURE RATES OF ANNUAL INCREASE AND IN HOSPITAL COSTS AND IN EARNINGS

(In percent)

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(4) Assumptions as to hospital utilization rates

The assumptions underlying the cost estimates for the committee bill are that hospital utilization rates will increase at 1% per year for the period 1971-75, at 1/2% per year for the period 1976-1980, and remain constant thereafter. No account is taken of the possibility that in-hospital care will be utilized to a much different extent than at present, but rather it is assumed that the long term upward trend in hospital utilization will continue for a while, and eventually level out.

(5) Assumptions as to hospital per diem rates underlying cost estimates for committee bill

Experience shows that, for 1969, the average daily reimbursement is about $54.37 which excludes the amount paid by the beneficiaries under the cost-sharing provisions. This was projected for future years in the manner described previously.

(f) Results of cost estimates

(1) Summary of cost estimate for committee bill

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The level-cost of the benefits and administrative expenses under present law is now estimated at 2.20% of taxable payroll. The level equivalent of the contribution schedule under present law is estimated to be 1.58% of taxable payroll. Therefore, the hospital insurance program under present law shows an actuarial deficit of .62 percent of taxable payroll.

To the level cost of the present program must be added (1) the cost of extending the hospital insurance program to the disabled who have been entitled to cash benefits for not less than 24 consecutive months, estimated at 0.46% of taxable payroll, and (2) the cost of the changes which introduced a co-payment feature from the 31st to the 60th day of hospitalization, and which extended the number of lifetime reserve days to 120, of which the net effect is estimated to be zero. The resulting level cost of the program over the next 25 years based on present law with respect to the earnings base ($9,000 in 1972) and on the assumptions previously outlined (and other less important assumptions with respect to costs and utilization of extended care facilities and home health services) is estimated at 2.66% of taxable payroll.

***5128** The financing of the hospital insurance program has been increased, in your committee's bill, in two respects; (1) the earnings base has been increased to $10,200 beginning in 1972, and can be assumed to follow the automatic principle thereafter, and (2) the tax rates have been increased as previously indicated. The first of these changes reduces the level cost of the program, expressed as a percent of future taxable payroll, to 2.58%. The second results in a level-equivalent value of future contributions estimated at 2.52% of taxable payroll. The resulting actuarial imbalance is -.06% of taxable payroll. This deficit is considered to be within an acceptable range of actuarial balance.

Table C gives a summary of the cost estimate for your committee's bill.

TABLE C.-Actuarial Balance of Hospital Insurance System, Expressed in Terms of Percentage of Taxable Payroll According to the Intermediate Cost Estimate based on 5 1/2 percent interest

(In percent)

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(2) Future Operations of hospital insurance trust fund

Table D shows the estimated operation of the hospital insurance trust fund under present law under the intermediate-cost estimate. Under present law the balance in the hospital insurance trust fund on an incurred basis is expected to decrease during calendar years 1971-72 and be exhausted sometime during 1973. This is due to the steep rise in hospital costs since program inception which was not anticipated when the previous tax schedules were enacted.

Table E shows the estimated operations of the hospital insurance trust fund under your committee's bill, according to the intermediate cost estimate. The year-by-year balances therefore reflect the benefit changes and additional financing in the bill as set forth previously. The increased tax rates on the higher maximum taxable wage base results in an increase in the trust fund balance to almost $6.5 billion at the end of 1972 which represents about 75% of total benefit and administrative expense outgo at that time. This desirable condition is expected to continue throughout the 25 year projection period: This is reflected in the gradual growth in the balance of the trust fund (at a rate of $1-$3 billion per year) up to over $38 billion at the end of 1995 which at that time represents slightly less than 70% of total expected outgo.

***5129** TABLE D.-PROGRESS OF HOSPITAL INSURANCE TRUST FUND, PRESENT LAW, UNDER ASSUMPTION THAT EARNINGS BASE IS KEPT UP TO DATE WITH INCREASES IN WAGES INCURRED BASIS, INTERMEDIATE-COST ESTIMATE [5]

(In millions)

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TABLE E.-PROGRESS OF HOSPITAL INSURANCE TRUST FUND, COMMITTEE BILL, UNDER ASSUMPTION

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THAT EARNINGS BASE IS KEPT UP TO DATE WITH INCREASES IN WAGES, INCURRED BASIS, INTERMEDIATE-COST ESTIMATE [5]

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

Hospital and related benefits are provided not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also on a 'free' basis for most other persons who were aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. The exceptions are non-insured persons who are active and retired Federal employees who are eligible (or had the opportunity of being eligible) for similar protection under the Federal Employees Health Benefits Act of 1959 or who are short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 qualify for the hospital benefits regardless of whether they have had any covered employment in the past, while ***5130** those attaining age 65 after 1967 must have some such coverage to qualify-- namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1966 and before the year of attainment of age 65 (e.g., 3 quarters of coverage for attainment of age 65 in 1968, 6 quarters for 1969, etc.). This transitional provision 'washes out' under present law for men attaining age 65 in 1975 and for women attaining age 65 in 1974, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under the bill, these requirements for noninsured men would 'wash out' at the same time as for women (due to the provision in the bill which would set the computation point at age 62 for men).

The benefits for the noninsured group who receive hospital insurance benefits on a 'free' basis is to be paid from the hospital insurance trust fund, but with financial reimbursement therefor from the general fund of the Treasury on a current basis, or with appropriate interest adjustment. The estimated cost to the general fund of the Treasury for the hospital and related benefits for this noninsured group (including the applicable additional administrative expenses) for various future years is shown in Table E. The estimated cost to the general fund of the Treasury for the closed group involved increases slowly to a peak of about $682 million per year in 1975-76 and then decreased steadily thereafter. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the factors of increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in the future years.

The foregoing discussion and cost estimates do not include the non-insured persons who, under the provisions of the bill, can voluntarily buy into the hospital program on the basis of their paying the estimated full costs involved.

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

(a) Extension of the SMI system to the disabled

Your committee's bill has substantially expanded protection provided by the supplementary medical insurance program, by extending its provisions, effective July 1, 1972, to disabled workers under 65 (and to disabled widows and widowers and to beneficiaries entitled to childs benefits based on disability which began prior to age 22) who have been entitled to cash benefits under the old age, survivors, and disability insurance system for no less than 24 months. The protection under the SMI system is automatic for these disabled beneficiaries although they may optionally dis-enroll.

The adequate actuarial rate for the disabled enrollees under 65 is likely to be much higher than the similar rate for the age 65 and older enrollees now under the program by a factor of about two and one-half times. The Secretary of Health, Education, and Welfare, under the terms of the bill, will in December 1971 and each December thereafter determine an adequate actuarial rate for the following fiscal year for those disabled enrollees under 65, and at the same time determine an adequate actuarial rate for enrollees age 65 or older.

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The premium rate charged disabled enrollees under 65 will be the same, however, as the rate charged enrollees 65 or older. Any difference ***5131** between the actuarial rate and the premium rate will be financed from the general fund of the Treasury, and whereas for enrollees 65 and older, the general revenue financing is approximately in the same order of magnitude as the enrollee premium (except under conditions stated in section (c) following), it is expected that the general revenue financing per enrollee for the disabled under age 65 is in the order of four times the enrollee premium.

The estimated level of general revenue financing made necessary by extension of the supplementary medical insurance program to the long term disabled under 65, in millions of dollars, over the first two fiscal years after the benefits become available is as follows:

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(b) Change in the SMI deductible

Your committee's bill changes the deductible amount under the supplementary medical insurance programs from $50 to $60, commencing with calendar year 1972.

The effect of this change in deductible amount will be reflected in the adequate actuarial rates determined by the Secretary of Health, Education, and Welfare to be effective for fiscal years 1973 and later.

For fiscal year 1972, the actuarial rate has already been determined and promulgated at $5.60 per month without regard to the increase in deductible amount, which will nonetheless be effective under the committee's bill during the second half of fiscal year 1972. The $5.60 rate will be slightly more adequate than it would have been had the deductible remained at $50 throughout fiscal year 1972, and the financial deficiency of the supplementary medical insurance trust fund, which has arisen from inadequate premium rates in the past, will be reduced somewhat.

(c) Limitation on Increase in SMI Premium Rate

Your committee's bill provides for the SMI premium rate to be promulgated during December of each year beginning with 1971 for the 12 month period commencing July 1 of the succeeding year (as is presently the case). However, the bill provides that the premium rate shall be equal to the 'acturial rate ' for enrollees 65 and over (as under current law), but subject to a limit equal to the premium rate in effect at the time of promulgation times a factor equal to 100% plus a computed rate of increase in cash benefits. This computed rate of increase in cash benefits is equal to the increase in the general level of cash benefits as they appear or will appear in the cash benefit tables for June 1 of the year in which the premium is promulgated and June 1 of the succeeding year.

Despite the limitation on the increase in the premium rate charged enrollees under the supplementary medical insurance program, the actuarial soundness of the program is not impaired. This is because the bill provides that the supplementary Medical Insurance Trust Fund be reimbursed from the general fund of the Treasury for any deficiency in the premium rate charged enrollees as compared to the adequate actuarial rate determined by the Secretary of Health, Education and Welfare.

***5132** (d) Financing policy

Coverage under the supplementary medical insurance program can be voluntarily elected on an individual basis, by virtually all persons aged 65 and older in the United States. Under your committee's bill those disabled beneficiaries entitled to cash benefits for 24 months or more under the old age survivors and disability insurance program are also covered under supplementary medical insurance (unless voluntarily disenrolled).

In the past the intention has been that the supplementary medical insurance program be entirely self-supporting from the premiums charged enrolled individuals and equal matching contributions from the general fund of the Treasury. Under the bill the self-supporting principle remains unchanged, but contributions from the general fund will necessarily be greater than on an equal matching basis. This increased financing share from the general fund arises for two reasons: (1) the premium rate charged eligible disabled enrollees under age 65 will be the same as that charged those age 65 and older, but the actuarially

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adequate rate for this group will be much higher, and (2) the limitation on the increase in the premium rate charged enrollees (see sub-section (c) above) may require that the premium rate charged enrollees aged 65 and over be less than one-half of the adequate actuarially determined rate, in which case the difference must be made up by payments from the general fund.

(e) Actuarial soundness of system

The supplementary medical insurance system is financed on a ‘current cost ‘ basis meaning that the premiums and general revenue contributions needed to support the system are based on actuarially determined rates that will change from time to time in accordance with experience as it develops and with experience anticipated in the near future. The actuarial soundness of the supplementary medical insurance program, therefore, depends only upon the ‘short-term‘ actuarial rates (for both the aged and disabled enrollees) being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are determined (including provision for the accumulation and maintenance of a contingency fund).

D. PROVISIONS RELATING TO ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

1. Purpose

The general problems that are discussed later with regard to the family welfare programs exist, but to a much lesser degree, also with respect to the present programs providing assistance to the aged, the blind, and the disabled. The programs, however-- characterized as they are by smaller numbers of people, smaller budgets and more nearly static beneficiary rolls are more susceptible to rapid and efficient reform than the family programs. Contributory social insurance and other sources of income-- private pensions, annuities, and other income from assets-- are sufficient to keep the total income of the majority of the aged, blind, and disabled from falling below the poverty line; it is your committee’s belief that, to the extent possible, contributory social insurance should continue to be relied on as the basic means of replacing earnings that have been lost as a result of old age, disability, ***5133** or blindness. But some people who because of age, disability, or blindness are not able to support themselves through work may receive relatively small social security benefits. Contributory social insurance, therefore, must be complemented by an effective assistance program.

Your committee, therefore, proposes a new assistance program for needy aged, blind, and disabled people, administered and financed by the Federal Government. Thus, the bill would repeal the existing title I (old-age assistance), X (aid to the blind) and XIV (aid to the permanently and totally disabled) of the Social Security Act. In place of these titles the bill would substitute a new title XX creating a single national program to provide cash assistance to the needy aged, blind, and disabled. Under the new Federal program, uniform eligibility requirements and uniform benefit payments would replace the multiplicity of requirements and benefit payments under the existing State-operated programs. The new program has been designed with a view toward providing:

1. An income source for the aged, blind, and disabled whose income and resources are below a specified level;

2. Incentives and opportunities for those able to work or to be rehabilitated that will enable them to escape from their dependent situations; and

3. An efficient and economical method of providing the assistance.

It is estimated that in the first year of the new program, 6.2 million aged, blind, and disabled people would be eligible for benefits. In fiscal year 1975, the first full year in which the program would reach the ultimate benefit level in the bill, it is estimated that 7.1 million aged, blind and disabled people would get $5.4 billion in benefits.

2. Eligibility

People who are age 65 or over, are blind, or are disabled and who have income and resources within the limits prescribed by the bill would be eligible for benefits.

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For an individual with no eligible spouse, the income limits are graduated from $780 ($130 a month) for the 6-month period ending December 31, 1972, up to $900 ($150 a month) for the 6-month period ending December 31, 1973, and $1800 ($150 a month) for any calendar year thereafter. An individual's resources (other than those excluded) may not exceed $1500.

For an individual with an eligible spouse, the income limits are graduated from $1170 ($195 a month) for the 6-month period ending December 31, 1972, up to $1200 ($200 a month) for the 6-month period ending December 31, 1973, and $2400 ($200 a month) for any calendar year thereafter. A couple's resources (other than those excluded) may not exceed $1500.

Your committee's bill would provide that the definitions of blindness and disability which are used in the disability insurance program established under title II of the Social Security Act would be generally applicable to disabled and blind people under age 65 under the new adult assistance program. These definitions, in the opinion of your committee, provide reasonable, objective, and fair tests of disability and blindness which are appropriate for the proposed program.

It is your committee's belief that disabled children who live in low-income households are certainly among the most disadvantaged of ***5134** all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society. Making it possible for disabled children to get benefits under this program, if it is to their advantage, rather than under the programs for families with children, would be appropriate because their needs are often greater than those of nondisabled children. The bill, accordingly, would include disabled children under the new program. Parents' income and resources would be taken into account in determining the eligibility and benefits of children under age 21.

A person would be considered disabled if he were unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted, or is expected to last, for not less than 12 months. A child under age 18 who is not engaging in substantial gainful activity would be considered disabled under the bill if he suffers from any medically determinable physical or mental impairment of comparable severity. An individual (other than a child under age 18), would be found disabled if his impairments are so severe that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

The term 'blindness' is defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. Also included in this definition is the particular sight limitation referred to as 'tunnel vision.'

In order to facilitate an orderly transitional process, those blind and disabled people who are on the benefit rolls in June 1972 under existing State programs would be considered blind or disabled for purposes of this program.

Your committee recognizes that under a needs program, it would be unreasonable to expect a claimant to pay for the medical evidence necessary to establish disability or blindness or even to provide the same extent of medical documentation required under title II of the Social Security Act. Thus, the Secretary would be expected to secure the needed medical evidence and the evidence was needed to make a sound determination.

Under the bill, a disabled individual who goes to work would be allowed a trial-work period in which to test his ability to work before a decision would be made as to whether or not his disability has ceased. Under the trial-work provisions, a disabled individual could work in each of 9 months, so long as he had a medically determinable disability, before it could be determined that his disability no longer prevented him from performing substantially gainful work. Any services he performs would not serve to demonstrate an ability to engage in substantial gainful activity during the 9-month trial work period. After 9 months of trial work have been completed, however, any work he had done would be evaluated to determine whether he had demonstrated an ability to engage in substantial gainful activity. If he had demonstrated this ability, it would be determined that he is no longer disabled.

***5135** While a person's work during the trial-work period would not be considered in a determination of whether he continued to be disabled during the period, any earnings (not excluded) he had during the period would be taken into account

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in determining his income and this would determine whether benefits were payable during the period and the amount of such benefits.

Benefits under the new program would be paid only to people who are residents of the United States, Puerto Rico, the Virgin Islands, or Guam and who are either United States citizens or aliens lawfully admitted for permanent residence. Residence abroad for a full calendar month would preclude eligibility for that month, and when an individual has been residing abroad for 30 consecutive days or more, he would not again be eligible for payments until he had returned to the United States for at least 30 consecutive days.

Your committee believes that those people who are disabled, in whole or in part, as a result of the use of drugs or alcohol should not be entitled to benefits under this program unless they undergo appropriate, available treatment in an approved facility, and the bill so provides. Your committee, while recognizing that the use of drugs or alcohol may indeed cause disabling conditions, believes that when the condition is susceptible to treatment, appropriate treatment of Government expense is an essential part of the rehabilitation process of people so disabled. Also, the Secretary would be charged with the responsibility of monitoring and testing those individuals undergoing such treatment, and would be required to submit to the Congress an annual report on his activities in this regard, with specific emphasis on the effectiveness of such treatment.

Under the new program, the Secretary of Health, Education, and Welfare would be required to determine an individual's eligibility for benefits for each quarter in a year. This does not mean, though, that quarterly investigations of all aspects of eligibility would be required in every case. Such frequent redetermination of disability in many cases, or of blindness in most cases, would serve no useful purpose. The Secretary would, therefore, have the authority to make redeterminations of blindness and of disability at such intervals as he considers reasonable and necessary, considering the severity of individual conditions and the purpose of the program, to assure that benefits are not paid to people who are no longer eligible.

In some cases, the financial status of beneficiaries will fluctuate during the year and periodic examination of an individual's income and resources would be needed in order to assure that benefits paid would be based on current income. Therefore, the Secretary ordinarily would make a redetermination as to income and resources on a quarterly basis. Somewhat less frequent redeterminations of income and resources, however, would be required in the cases of the very old, blind, or aged recipient, or the extremely disabled-- cases where large increases in income are unlikely. Whenever changes in income do occur, however, they would have to be reported and appropriate adjustments in the amount of benefits payable would be made.

Beneficiaries and prospective beneficiaries would be required to apply for, and make every effort to obtain, any other payment-- whether or not based on need-- for which they might be eligible. Your committee believes that the new program, financed as it would be from general revenues and with the benefits based on need, should pay people ***5136** only to the extent that their needs are not met from other sources, including, among others, social security payments, payments by other agencies, and payments from private pension plans. Therefore, an individual who does not take all appropriate steps to obtain such payments within 30 days of the date that he applies for benefits under this new program would not qualify for any payments under the program and any benefits which had already been paid would be considered overpayments. Of course, if the time limit on other conditions with respect to other benefit could not be met, or applying for the other benefit would otherwise be futile, the provisions would not operate.

3. Benefits

Assistance payments are now made under 54 different programs, with varying tests of need and varying income exclusions. For example, under State old-age assistance programs as of July 1970, the amount paid for basic needs to an aged couple with no other income ranged from a low of $97 a month to a high of $350 a month.

The new benefit standards for assistance to the aged, blind, or disabled are as follows:

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The benefit payable to a couple is smaller than the combined benefits payable to two individuals in order to take account of the fact that two people living together can live more economically than they would if each lived alone.

In determining marital status, State law will apply, except that, if a couple has been determined married for purposes of

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receiving social security benefits or if they hold themselves out as married in the community in which they live, they will be considered married for purposes of the new program. In the absence of such a provision in the assistance program, there would be a strong incentive for married couples to allege that they were not married (in order to get higher payments) and there would be a difficult, if not impossible, administrative burden of determining whether a marriage existed between two individuals alleging to be single (but who hold themselves out to be married). Also, to avoid encouraging couples to live separately in order to get the higher total benefit, your committee's bill provides than an eligible individual and spouse will receive a couple's benefit even though they live apart.

People who are residents of certain public institutions, or hospitals or nursing homes which are getting Medicaid funds, would get benefits of up to $25 a month (reduced by nonexcluded income). For these people most subsistence needs are met by the institution and full benefits are not needed. Some payment to these people, though, would be needed to enable them to purchase small comfort items not supplied by the institution. No assistance benefits will be paid to an individual in a penal institution.

***5137** 4. Determination of income and resources

(a) Definitions of income.-- Income for purposes of your committee's bill includes both earned and unearned income. Earned income is defined generally by reference to the definition of earnings for earnings test purposes under the old-age, survivors, and disability insurance (OASDI) program and includes both wages and self-employment income.

Net earnings from self-employment are defined in the bill by reference to the present definition applicable to the OASDI program with the exception of certain provisions of that definition which your committee believes inappropriate for this program, such as the special provision under which a farmer's net income may be presumed to be a given percent of his gross income.

For an eligible individual (or spouse) who is blind or disabled (including an individual over age 65 who was receiving benefits under the program on the basis of disability or blindness in the month prior to the month in which he attained age 65), the first $85 a month of earned income of the individual and his spouse and one-half of the earnings above $85 (plus work expenses for a blind recipient and his spouse would be excluded from consideration. For an eligible individual who is age 65 or over (and his spouse), except those mentioned above, the first $60 a month of earned income plus one-third of the remainder would be excluded from consideration.

This provision would work as follows: Assume that, in 1975, an aged individual who is eligible for a payment of $150 a month gets a steady part-time job as a night watchman and makes $100 a month of earned income. The first $60 of his $100 monthly earnings would be ignored, and of the $40 remaining, one-third, or $13.33 would be excluded, leaving him with nonexcludable income of $26.67, which would be rounded to $26. This $26 would reduce his payment to $124 a month, which, together with his $100 of earnings would give him $224. If this man had an eligible wife, her earnings would be combined with his in determining the amount of the couple's benefit. (The earnings of an eligible or noneligible spouse would be considered in determining benefit amounts.) Thus, if the wife had earnings of $50 per month, the couple's earnings of $150 per month would be treated as if they were all earned by one individual. The $150 would be reduced by $60, leaving $90. One-third of this amount ($30) would be excluded, and the couple's benefit of $200 would be reduced by $60 to $140 a month, which, together with the $150 of earnings, gives them $290 each month.

The larger exemption for the blind and disabled would apply to the combined earnings of a couple if either the husband or the wife is blind or disabled.

Income which does not fall within the bill's definition of earned income would be considered unearned. However, certain forms of remuneration which are specifically excluded from the OASDI definition of earnings are not to be considered as income. For example, contributions by an employer into a health insurance or retirement fund for his employees are a form of remuneration but such contributions would not be considered income-- earned or unearned-- for the individual employees.

The kinds of income which would be considered unearned include annuities, prizes and awards, proceeds of life insurance not needed ***5138** for last illness and burial (with a maximum of $1,500), gifts, support payments, inheritances, grants, dividends, interest payments, as well as benefits from all other public and private pension, disability, or unemployment

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programs.

The distinction between earned and unearned income is significant because of the fact that special deductions would be applied to earned income which would not be applied to unearned income.

In recognition of the practical problems that would be encountered in determining the value of room and board for people who live in the household of a friend or relative, the bill would provide specific rules for use in these situations. Under the bill, the value of room and board, regardless of whether any payment was made for room and board, would be assumed to be equal to one-third of the applicable benefit standard. For example, an individual who was entitled to a monthly benefit of $150 on the basis of a disability and who lived in the home of his son would have his monthly benefit reduced to $100 whether or not he paid for his room and board. On the other hand, if the individual lived in a rooming or boarding house, there would be no reduction in his benefit.

Special treatment of earnings of blind or disabled children who are students is needed in order to help finance and encourage continued school attendance. Therefore, the earned income of such children regularly attending school would be excluded, subject to limitations set by the Secretary. (A 'child' for purposes of the new program is a person who is not married, is not the head of a household, and is under age 18-- or under 22 if a full-time student.) Also, any portion of a grant, scholarship, or fellowship that is received for use in paying tuition costs would be excluded. Any portion of these payments which is used for general living expenses would, however, be included as unearned income.

Resources and income in the case of a blind or disabled child under age 21 are deemed to include the resources and income of a parent if they live together.

In line with your committee's desire to provide every opportunity and encouragement to the blind and disabled to return to gainful employment, the new program, in addition to providing them with a higher earned-income exclusion than is provided for the aged, would permit the blind and disabled and their spouses to exclude additional income that is needed to pursue a plan that has been approved by the Secretary for achieving self-support and your committee intends that these provisions be liberally construed if necessary to accomplish these objectives. A blind person, for example, might be getting $80 per month from a brother, in addition to, say, $100 a month he is earning himself. If the money from his brother were being saved for the establishment of a business-- possibly a magazine stand or small store-- which could help him make him self-supporting, the money could be excluded if the Secretary approved his plan to establish a business.

Your committee has also included a provision in the bill under which other assistance payments provided on the basis of need by a public agency, or by certain private tax exempt organizations would have no effect on assistance benefits under the new program. State or local government payments (including those from Indian tribes) to supplement the Federal benefits provided under this program, however, would be excluded from income only if the State supplemental payment is ***5139** described in an agreement with the Secretary which would provide that the payments do not undermine the earnings incentive, disregard provisions of the Federal program.

The new program would provide that unearned income, in addition to other excluded income of $60 or less and earned income of $30 or less in a quarter, if received irregularly or infrequently, would not reduce a person's benefit. Under this provision, a small gift and insignificant earnings from occasional work would be excluded from income.

Home produce used by members of the household for their own consumption would be excluded because of the administrative difficulties involved in determining the value of such produce and because there is generally very little economic advantage resulting from produce raised and consumed at home.

One-third of any payment received from an absent parent for the support of a child eligible for benefits under the program would be excluded from income.

Income received by eligible individuals for the care of a foster child placed in the individual's home by a public or nonprofit child placement or child-care agency would also be excluded. Your committee believes this exclusion would permit a needy individual to continue as a foster parent and to furnish a home and guidance to a needy child.

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(b) Excluded resources.-- An individual (or an individual and his eligible spouse) with resources in excess of $1500 would not be eligible for payments under the program. However, in determining resources for purposes of eligibility certain resources would be wholly or partially excluded.

An individual's home, household goods, and personal effects would be excluded, within limits determined by the Secretary of Health, Education, and Welfare (which would generally follow State practices permitted under the present program). Because household goods and personal effects generally are not counted as resources under most of the present programs, it seems appropriate to continue their exclusion under the new program.

The bill also contains an exclusion of resources essential to an individual's means of self-care or self-support, such as an automobile needed for purposes of employment, the tools of a tradesman, farm machinery, and the inventory of a small business. Your committee believes that if a recipient needs an automobile for necessary transportation, such as to obtain needed medicare treatment, it also should be an excluded resource.

Life insurance policies would not be counted as resources if the total face value of the policies is not more than $1500. In the case of a husband and wife, each could have insurance policies of up to $1500 face value. Otherwise, the cash surrender value of an insurance policy would be counted as a resource.

Resources in excess of $1500 that are readily convertible to cash, such as stocks and bonds, would be counted as a resource in determining an individual's eligibility for assistance benefits. Your committee believes that where income producing property is not used as part of a trade or business, the value of such property should be excluded from the resources limitation only to the extent it is producing a reasonable return and the bill so provides. The exclusion would be based on a ***5140** fixed percentage return, to be set forth in the regulations of the Secretary, in order to permit adjustments for changing economic conditions. Property not used in the operations of a trade or business and which does not provide a reasonable return should clearly be included as resources. Assets such as buildings or land not used as the individual's abode (which is excluded as described above) which are not readily convertible to cash must be disposed of within a time limit prescribed by the Secretary of Health, Education, and Welfare. The Secretary, however, may pay conditional benefits during the period allowed for disposal of these assets. Any proceeds resulting from the disposition of the assets would be taken into account in determining eligibility for benefits. The individual would be obligated to return the conditional benefits to the extent that such benefits would not have been payable if the proceeds had been taken into account at the time the person started getting the benefits.

5. Vocational rehabilitation

Many blind and disabled people want to work and, if the opportunity for rehabilitation for suitable work were available to them, they could become self-supporting.

Under the new program, all individuals under age 65 who are receiving assistance benefits based on disability or blindness would be referred to the State vocational rehabilitation agencies for rehabilitation services. The Secretary would be authorized to pay the full costs of the vocational rehabilitation services provided to qualified individuals; the primary objective is to restore as many as possible to productive activity.

Every disabled or blind person who is offered rehabilitation services would be required to accept such services. No individual would be eligible for benefits if he refused without good cause to accept rehabilitation services.

6. Payment of benefits

While your committee believes that in a program such as it proposes benefits generally should be paid monthly, it recognizes that situations will occur in which the needs of particular beneficiaries can be met by other than monthly payments or where monthly payments would not be consistent with good administration. The bill, therefore, would provide the Secretary with discretionary authority to make payments at such times as he deems appropriate in light of the particular circumstances. In addition, the Secretary would be authorized to make payments on behalf of a beneficiary to some other person (including an appropriate public or private agency) when it appears to him that the other person has an interest in the beneficiary and payment to the other person would be in the beneficiary's interest.

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When a husband and wife are entitled to benefits, each may be paid one-half of the total monthly benefit.

In the interest of efficient administration and to permit the rounding of income and benefits, the Secretary would be permitted to establish ranges of income-- that is, to use income brackets within which a single benefit amount would apply.

Your committee's bill also provides that payments may be made to individuals initially applying for assistance benefits when there is strong evidence of the likelihood of eligibility and if they are faced ***5141** with financial emergencies.Advances of up to $100 against future benefits may be paid to each such applicant, where the applicant is presumptively eligible for benefits.

A special provision for the disabled would be made in recognition of the fact that in some cases additional time is needed to obtain and evaluate medical and other evidence to establish disability, and that a mechanism is needed for meeting living costs during the period in which a formal determination of disability is pending. Under this provision, applicants for disability benefits could be paid up to 3 month's benefits when a prima facie case for determining that a disability existed had been presented. In order to avoid any interruption in benefits to an eligible disabled person, your committee expects that the Secretary will make the initial determination of disability before the end of the 3-month period. Any benefits paid on the basis of this special provision would not constitute an overpayment that would have to be recovered in the rare case where an individual later is found not to have been disabled.

7. Procedural and miscellaneous matters

(a) Overpayments and underpayments-- Your committee's bill would provide that whenever the Secretary finds that an individual had been paid more than the correct amount of assistance benefits, the Secretary shall recover the overpayment and, as one way of accomplishing this may decrease any payment under this title to which such overpaid individual or his spouse is entitled until such time as the overpayment has been repaid. The Secretary could waive overpayments in the interest of equity where the overpaid individual was without fault. Also, if less than the correct amount of benefits had been paid, the Secretary would pay the balance due to the underpaid individual. If the individual dies before the amount due has been paid to him, or before he negotiates the check representing the correct payment, the amount due would be paid to his eligible spouse, if there is one, and the payment would not be taken into account in determining the spouse's need under this program. Underpayments, however, would not be paid to the estate of a deceased individual since that would not further the objective of meeting the current needs of individuals. Overpayments, on the other hand, could be recovered from the estate of a deceased individual.

(b) Beneficiary reports.-- Beneficiaries would be required to report any changes in circumstances, as the Secretary deems necessary, to determine continued eligibility or any necessary changes in benefit amounts. An individual's willful failure to submit reports requested by the Secretary, or willful failure to submit reports requested by the Secretary, or willful delay in submitting such reports, would be cause for the Secretary to reduce the individual's benefit by $25 in the case of the first such failure or delay, $50 in the case of the second, and $100 in the case of the third or subsequent failure or delay.

(c) Hearings and review.-- Your committee's bill requires that there be notice and opportunity for hearings for any individual who disagrees with a determination with respect to eligibility for payments or the amount of the payments. The individual would have to request the hearing within 30 days after receiving notice of the determination. Decisions would be rendered within 90 days following a properly submitted request for a hearing (except that the 90 day requirement would not apply when a hearing is held to determine whether a person ***5142** is disabled). If payments during the hearing process were continued they would be considered overpayments if the Secretary's initial determination were sustained. Final determinations of the Secretary would be subject to judicial review in the Federal district courts. However, determinations as to the facts which the Secretary makes after a hearing provided by him would be conclusive and not subject to judicial review.

Your committee recognizes that many qualified persons who would be capable of hearing issues that arise under the program may not meet the specific requirements for appointment as hearings examiners under the Administrative Procedure Act, but might be a good source of examiners to hear issues arising under the program. Therefore, under your committee's bill, the Secretary would establish the requirements to be used in selecting examiners. Although the examiners would not be selected under the conditions set forth in the Administrative Procedure Act, full hearings would otherwise be conducted in accordance

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with the requirements of such act which include, for example, the right to submit evidence, to cross examine witnesses, to be heard by an impartial examiner, and to a decision based on the hearing record.

Where an individual who has requested a hearing is represented before the Secretary by an attorney, the provisions of the cash social security program (pertaining to attorney fees) would be applicable except that there would be no withholding of attorney fees from such individual's benefits. Your committee believes that to withhold such fees would be contrary to the purpose of the program.

Also, the protective rules and regulations on representation of claimants that apply to the old-age, survivors, and disability insurance program would be applied to the assistance program.

(d) Prohibition of assignments; rulemaking authority; subpoena power.-- Your committee wishes to emphasize its strong belief that if the benefits which would be provided under this program are to meet the most basic needs of the poor, the benefits must be protected from seizure in legal processes against the beneficiary. Therefore, any amounts paid or payable under this program would not be subject to levy, garnishment, or other legal process, except the collection of delinquent Federal taxes. Also, entitlement to these benefits would not be transferable or assignable.

The Secretary would be authorized to establish rules, regulations, and procedures necessary to administer the new program and to prescribe the evidence required to qualify for the assistance benefits that would be provided.

The Secretary, for the purpose of any hearing or other proceeding authorized under this program could issue a subpoena requiring the attendance and testimony of witnesses and the production of evidence relative to any matter in connection with hearings or proceedings. In case of contumacy, or refusal to obey a duly served subpoena, the proper United States district court could, upon application by the Secretary, issue an order to comply with such subpoena and failure to obey such court order could be punished as contempt of court.

The bill would also provide that the privilege against self-incrimination would not excuse any person from testifying, but that he would not be prosecuted or subjected to a penalty or forfeiture on account of ***5143** any matter concerning which he is compelled to testify after claiming his privilege against self-incrimination, except in case of perjury.

(e) Furnishing of information by other Federal agencies.-- Your committee's bill would require that the heads of all Federal agencies provide such information as the Secretary may require for purposes of determining eligibility for benefits under this title. Secretary may require for purposes of determining eligibility for benefits under this title. For example, the records of the Social Security Administration would be made available in verifying information as may be needed.

(f) Fraud.-- The bill would provide a fine of not more than $1000, or imprisonment for not more than one year, or both, for individuals convicted of fraud in connection with a claim for benefits. The penalties which would be provided by the bill are the same as those provided for fraud under title II of the Social Security Act.

(g) Evaluation and research reports.-- Annual reports by the Secretary to the Congress and the President on the operations and administration of the program, and on its impact on related programs would be required.

Authorization is given to the Secretary to conduct research and demonstration projects. Since such experimentation may well involve approaches or other ideas which have no specific sanction in existing statute or regulations, authority is also provided for the Secretary to operate narrow experiments involving limited numbers of people and in limited geographic areas without regard to the eligibility and payment provisions of the program.

An appropriation of up to $5 million a year would be authorized to carry out these functions.

(h) Disregarding of certain income in determining need for aid to the aged, blind, or disabled.-- One provision in the **Social Security Amendments** of 1969 required, in effect, that the States increase their payments for the aged, blind, and disabled by $4 per month beginning with April 1970, the first month in which the social security benefit increase also provided in such amendments was first paid. Alternatively, States were permitted to disregard $4 per month of such increase for these aged, blind, and disabled assistance recipients who were also eligible for social security benefits. This provision would expire on

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January 1, 1972, under present law.

Under your committee's bill, this provision of the **Social Security Amendments** of 1969 would (1) be made permanent, and (2) would be made to apply to any optional State supplemental payments made under the new program.

(i) Administration.-- In the course of the deliberations leading up to your committee's decision to recommend the new federally administered program, it became convinced that successful administration of the proposed plan could be achieved by utilizing the administrative structure of the Social Security Administration. (The 50,000 employees of the Social Security Administration operate out of more than 850 offices located in various communities scattered all over the country and provide regular service in an additional 3,500 contact points to all those seeking benefits and information, including appropriate services to those who do not speak English.) In light of this advice, your committee believes that the new program can be operated efficiently by the Social Security Administration. There is, however, some apprehension that administration of the new program and the existing social ***5144** security programs by a single agency could lead to confusion between the new assistance program and the old-age, survivors and disability insurance program. In this regard, your committee emphasizes strongly its position that while a single agency might administer the programs, there is no intent to merge the new assistance program with the existing social insurance program. Each is to maintain its unique identity and this uniqueness would be stressed by requiring separate applications and reports for each type of benefit and in particular by issuing separate benefit checks.

In order to achieve an orderly transition from the present State programs, your committee's bill would provide that during the first year of the program, interim agreements could be made between the States (including Puerto Rico, Guam, the Virgin Islands, and the District of Columbia) and the Secretary of Health, Education, and Welfare. These agreements would provide for a State to administer, on behalf of the Secretary, the new Federal program for the aged, blind, and disabled during a part or all of such year. The Secretary could begin taking applications before July 1972 and provide technical assistance to the States to facilitate the takeover of State records.

Your committee recognizes the practical problems involved in determining how the actual disbursements for administrative expenses should be made when the same offices will be providing services for both the OASDI program and the new adult assistance program. Therefore, it may be necessary when payments are to meet the joint costs of administering the existing social security programs as well as the proposed new program, to make the initial disbursements from the OASI trust fund and the bill provides for this authority. If any disbursement should be made from the social security trust fund to pay any of the administrative costs of the new program, it would be considered as an administrative convenience only and moneys should be promptly repaid to the trust fund, with an additional payment to make up for any interest earnings that were lost to the trust fund as a result of the transaction. Any disbursements from the trust fund for the administrative expenses of the proposed assistance program must be fully covered in advance by available appropriated funds; in no sense should the procedure be looked upon as a shortcut around the regular appropriation process or as a way to under cut limitations contained in enacted appropriations. Moreover, the bill would provide that the authority to make expenditures out of the trust fund would expire after any fiscal year for which advances from the trust fund, including payments in lieu of lost interest, had not been repaid.

E. FAMILY PROGRAMS

1. The outline of welfare reform for needy families

(a) Critical need for a new approach to welfare.-- The present aid to families with dependent children programs (AFDC) as operated by 54 separate jurisdictions are characterized at one and the same time by--

(1) a large and growing lack of confidence on the part of the taxpaying public that assistance goes only to those who need it and does not go to those who are indolent or ineligible;

***5145** (2) understandable bitterness from those who must depend for help upon a system that in too many cases extracts self-respect as the price of its benefits.

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(3) hopelessness from those who have been trapped in a life on the dole, from which the possibility of escape seems remote;

(4) contempt from those who all-too-easily obtain undeserved benefits from an antiquated, unstable and lax welfare bureaucracy;

(5) a crazy quilt pattern of benefits and eligibility requirements that makes little sense in a highly industrialized and mobile society; and

(6) incentives for more and more welfare, less and less work, and for family disintegration.

The effects of these factors can be measured by the geometrically increasing costs and caseloads in the 1960's. From the beginning of 1960 to the end of 1969, the AFDC rolls grew by 4.4 million people, a 147 percent increase. The total costs of the program more than tripled from about $1 billion in 1960 to about $3.5 billion at the close of the decade.

If the situation in welfare was alarming and in a state of crisis at the beginning of 1970, the AFDC program is now completely out of control. January 1971 expenditures for aid to families with dependent children were $482,423,000-- a 40.5 percent increase over the previous January. The number of AFDC recipients rose from 7,501,000 in January 1970 to 9,773,000 in January 1971-- 2 1/4 million more people in one year.

Immediate and far-reaching action is needed. Attempts to patch up the present system or to close its loopholes simply will not work and would lead to nothing but disillusionment and recrimination. The legislation which your committee is recommending is clearly needed now to prevent the collapse of a basic function of government, assisting its poorer citizens to a better life. The bill would establish entirely new programs to carry out this function of government in a modern way.

The new programs which your committee recommends have the following main elements--

(1) the separation of needy families into two groups, those with an employable adult (including families where the father is working full time for low wages) and those without an employable adult, with appropriate help tailored for each group;

(2) incentives and requirements for work, training, and rehabilitation;

(3) a heavy investment in the training, rehabilitation, and job placement of poor families with expanded child care, manpower training, public service employment, and family planning efforts;

(4) uniform requirements for eligibility for cash assistance, susceptible of effective, uniform administration with specific limitations and requirements and

(5) as a support for the entire program, an efficient, modern, and national administrative mechanism designed to assure that only those who are eligible receive benefits, while avoiding unproductive red tape and delay.

(b) Separation of poor families into two groups.-- All eligible families would be divided into two groups under separate programs tailored to meet each group's particular needs. Families with an adult available ***5146** for employment (which term is defined precisely and described in more detail below) would be enrolled in the Opportunities for Families program administered by the Secretary of Labor would be furnished the necessary authority and funds to enable him to carry out his responsibility to help families to rehabilitation and self-support.

All other families, including those where an adult is incapacitated, would be enrolled in the Family Assistance Plan. The Secretary of Health, Education, and Welfare would be responsible for this program, including arrangements for vocational rehabilitation services to incapacitated family members.

About 2.6 million families would enter the Opportunity for Families program and about 1.4 million families would be in the Family Assistance Plan in the first full year.

Under present law, the low-income family headed by the father is not eligible for AFDC if he is working full-time, and in 26

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States even if he is unemployed. The family headed by a female, on the other hand, is eligible whether she is working full-time, part-time, or not at all. This anomaly is not only inequitable on its face but leads to severe economic pressures for a father to leave his family. He finds himself in the untenable position of being able to assure that his wife and children are properly fed and clothed only if he leaves them. It is not unlikely that this situation is related to the fact that female-headed families are increasing three times faster than the population generally. These incentives are, of course, exactly contrary to good public policy. Clearly, the incentives should be in the direction of keeping the father with his family in order to support them. Since male-headed families would be brought under the new program, proper incentives and controls would be introduced into the system, and an eventual reduction in the rate of family break-up can reasonably be expected.

(c) Incentives and requirements for work, training and rehabilitation.-- The new plan would substitute exact rules to determine who must register for work or training for the haphazard system today under which each State decides who is required to register. Under the bill, any member of an eligible family who did not meet specific criteria would be considered available for employment and would have to register with the Secretary of Labor for work and training.

Any person who did not register or take work or training as required would subject the family to a penalty of an $800 per year reduction in benefits. Every person taking training would receive about $30 a month as an additional incentive to stay in the training. (Thus, the monetary difference between refusing to taking training could be $1,160 a year.) The same penalties and allowances would apply to people who are offered vocational rehabilitation services.

As an incentive for work the first $720 plus one-third of the remainder of annual earnings would not be used to reduce the family benefits.

(d) Increased investment in manpower training, rehabilitation, child care, public service employment, and family planning services.-- The new approach to welfare would have a solid base of support for activities to get people into work and self-support. Your committee's bill would authorize appropriations for various supportive services for the programs as follows:

Child care: $700 million for services (plus $50 million for construction), equivalent to more than 875,00 child care slots.

***5147** Public service employment: $800 million, equivalent to 200,000 jobs.

Manpower training and placement activities: $540 million, equivalent to 412,000 slots in addition to the 187,000 now authorized; includes 75,000 slots for upgrading jobs of those now working in low paid jobs.

Other supportive services: $100 million for additional services such as minor medical services and transportation needed to support efforts to help families attain self-support. The bill would require family planning services to be offered to all appropriate family members.

(e) Uniform requirements and elements of eligibility for cash assistance.-- Your committee's bill would establish a single system of family benefits with uniform eligibility requirements for what is now a varying system of 54 different plans in 54 jurisdictions under only general Federal guidelines.

(f) Administrative arrangements and safeguards.-- Your committee has become convinced that the major key to the success of a program to assist the poor of the nation is an effective, efficient administrative mechanism which has both the confidence of the taxpaying public and the respect and cooperation of those who apply for its benefits. Your committee, therefore, has directed a great deal of attention both to the specific provisions in the bill which would create such an administrative mechanism and to working out with the Secretary of Labor and the Secretary of Health, Education, and Welfare the system of administration which will characterize the proposed program in its day-to-day operations.

Your committee believes that maintaining the integrity of the program requires that eligibility for benefits under this program must be established by suitable and convincing evidentiary materials, such as birth certificates. There will be no simple declaration process. Moreover, continuing eligibility must be shown by timely income reporting with failure to do so resulting in suspension of benefits and specific dollar penalties. Social security and income tax records would be used to verify the accuracy of earnings reports and to avoid duplicate payments. A requirement for reapplication every two years

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emphasizes your committee's intent that receipt of benefits should be a temporary status and not a way of life.

The bill also provides that a father or mother who deserts his or her family will be responsible to the Federal government for every penny paid to the family. If the debt cannot be collected in any other way, the government will withhold all Federal payments of any sort to the deserting parent until the debt is paid. In addition, the bill would make it a Federal crime for an individual to cross a State line in order to escape the financial responsibility to support his family.

(g) Immediate steps to correct present program.-- Your committee's bill would make the new programs effective just as soon as it is possible to put them into operation. That date is July 1, 1972, for the families covered under the present program and January 1, 1973 for families with a fully employed father. However, your committee is well aware that the present program is in dire need of immediate stopgap measures even during that short period of time. Therefore, the bill contains several provisions to deal with certain problems in the present program. These changes would support the efforts of several of the ***5148** States which have come to see that prompt action is needed at that level of government.

(h) Conclusion.-- In short, every possible step will be taken under the new programs to assure that only those eligible for the benefits will get them. Your committee is convinced, both on the basis of specific studies and on the testimony of witnesses before the committee, that there are many thousands of people now on the AFDC rolls who do not belong there. There is evidence that there are people on welfare who do not report their earnings. There is evidence that some fathers have only seemed to have separated from their families, while actually remaining a part of the family, and providing support to the family which the welfare office never learns about. Under the provisions of the bill, your committee expects that such practices would be eliminated.

In approaching the nation's welfare problems, which are now enormous and complex, your committee has developed a program which is in the interest of the taxpayers as well as the needy. For it is only by having a program that merits continued public support that we will be able to assure adequate assistance to those who truly need it.

2. The Opportunities for Families program

(a) Separation of employables and unemployables-- responsibility of Department of Labor.-- Two basic difficulties have appeared in past legislative efforts to return welfare recipients to self-sufficiency: (1) all recipients have been lumped together without any expert or realistic assessment of their ability to enter the labor force, and (2) authority for employment and training programs has been diffused at both the Federal and local level, with the other agency always being blamed for program deficiencies. The reported bill meets these problems by creating an entirely separate program for those who are defined under the bill as available for employment and by providing that this new program would be the complete and exclusive responsibility of the Department of Labor.

(b) Requirement to register for training or employment.-- Your committee was faced with the very difficult task of deciding who should be required to take training or enter employment and who should not. The weakness of the 1967 welfare amendments was that the clear congressional intent of getting able-bodied welfare recipients (including mothers where there was adequate day care available) into work and training was effectively diluted by Federal and state welfare officials who did not share this objective with equal enthusiasm.

Your committee has concluded that administrative discretion should be minimized, and that the law itself should be as specific as possible with respect to those who are to be expected to work and those who are not.

The bill reported by your committee would require all adults to register with the Secretary of Labor unless they were specifically exempted by the law itself, thereby eliminating the kind of broad discretion which now exists in the Work Incentive Program (WIN).

(1) Exclusions from the requirement to register would be made in the case of individuals who are so ill, incapacitated or of advanced age that they are unable to engage in gainful employment. The Secretary of Health, Education, and Welfare, with concurrence from the Secretary of Labor, could by regulation prescribe when the age of a particular ***5149** person, taking into account the person's health, education, and former training and any other pertinent conditions, was so advanced as to make registration unnecessary.

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The term ‘incapacity‘ might include under some circumstances individuals who are drug addicts or alcoholics. Addicts or alcoholics who would be required to register but for drug or alcohol abuse would be referred to clinics or treatment facilities already in existence and especially designed to meet their problems. Such family members would have to participate fully in treatment programs and undergo training provided in order to be eligible for federal payments.

(2) Your committee’s bill would also exclude from mandatory registration children who are under age 16 or under age 22 if they are students regularly attending school. Your committee believes that the training aspects of the program could be of great use in preparing for employment youths age 16 and 17 who are not attending school, and has therefore required them to register.

(3) A mother (or other adult caretaker) of a child under the age of 3 (under age 6 until July 1974) who is actually caring for the child is not required to register. As a practical matter, the committee expects a large percentage of these mothers to register voluntarily for employment and take advantage of the child-care provisions, training incentives, and allowances and employment opportunities under the bill. That has been the experience under the present WIN program where about 7 out of 10 of the mothers enrolled have children under the age of six. For the first two years, during which time more adequate child care facilities can be created for young children, the exemption would apply to mothers with children under 6 years of age.

Your committee understands the reasoning of those who are concerned about the requirement that mothers of young children register for and take work and training. However, two primary considerations led your committee to the decision reflected in this provision of the bill.

First, about 5 million mothers with children under age 6 are now in the Nation’s labor force. Further, the number and proportions of mothers who choose to and do work is increasing steadily. About 4 out of 10 mothers with children under age 18 are now in the labor force, compared with 1 out of 10 in 1940. More than half of all mothers with children age 6 to 17 are now in the labor force, compared with one-third in 1950. About one-third of mothers with children under 6 are now in the labor force, compared with only 14 percent in 1950. It seemed to your committee that to require such women to support out of taxes on their earnings those mothers who choose not to work but to live on public monies would be inequitable in the extreme.

Second, your committee is convinced that, by and large, the child in a family eligible under these programs will benefit from the combination of quality child care and the example of an adult in the family taking financial responsibility for him. Nor should it be forgotten that the mother who takes the training or gets a job will have more money available to improve the family’s circumstances and more adequately provide for the children.

(4) An additional exclusion is provided for the mother or other female caretaker of a child if the father of the child is required to register and does so register. These mothers would also be entitled to voluntarily register for training and employment. If the father in this ***5150** situation refused to register, however, the mother would have to register.

(5) A person whose presence in the home is required on a substantially continuous basis in order to care for an ill or incapacitated member of the household would not be required to register. This type of illness or incapacity would in almost all cases be required to be more severe than the type discussed under (1) above, since the disability would have to be such as to require a regular caretaker.

Your committee’s bill would not exclude from the registration requirement the father or mother who is working full-time. They will thus have the possibility of being able to find jobs at higher wages, and will be able to benefit from training designed to upgrade their skills.

The Secretary of Labor is required to furnish adequate child care services for so long as he determines necessary when registrants need such services in order to participate in manpower services, training, or employment. No mother would be required to undertake training or employment without the assurance of adequate child care.

(c) Requirement for those who register to accept training or employment.-- In addition to the requirement to register, there would also be a requirement to accept training or employment in which a person is ‘able to engage. ‘ Refusal to accept

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training or employment, unless the refusal was for 'good cause,' would result in a substantial penalty. If, for example, the father (or other individual required to register) refused training or employment, $800 annually would be subtracted from the benefit checks. Further, under such circumstances the Secretary could not pay the remainder of the family's benefits to the Father and could, if he found it appropriate, make the remaining family payment to someone outside the family who is interested in or concerned with the welfare of the family.

An individual may refuse work or training for 'good cause.' Such protection is provided in the bill because it is impossible to anticipate all the situations in which it would clearly be unreasonable to require acceptance of a job. Your committee intends, however, that exceptions be made ony when it is clearly unreasonable and a hardship would be imposed on the individual concerned. It is intended to be applied only in clear cut situations where the individual's reasons are sound and compelling. For example, a mother should not be expected to take a job if child care has not been provided. A man should not be forced to take a job that is 50 miles away from his residence and adequate transportation is unavailable. On the other hand, individuals would be required to travel a reasonable distance for work. For example, an individual living within the District of Columbia would be required to take a job available within the metropolitan area if transportation was available.

Your committee has written into the bill certain specific exceptions to the work requirement. An individual need not accept a job if--

The job is vacant because of a labor dispute;

The wages are below the applicable legal minimum or below the prevailing wage for similar work. In no case would employment be required that paid wages below 75% of the highest Federal minimum wage, (which would be $1.20 per hour under current law); or the individual would be required to join a company union, or be prohibited from joining a bona fide union.

***5151** The legislation being reported would also permit refusal of a referral to a job if the individual has a demonstrated capacity, through other available training or employment opportunities, of securing available work that would better enable him to achieve self-sufficiency. For example, if a man who was skilled as a welder could demonstrate that a welder's job was available, the manpower agency would be expected to refer him to it. If it were not available, then the person would have to take some other job that was available, even though it paid a good deal less than the welder's job.

The requirement that the job to which an individual is referred pay no less than 75% of the maximum Federal minimum wage would recognize that there are about five and one-quarter million persons who now work for less than the Federal minimum wage of $1.60 per hour. It would be inequitable to excuse adult family members from such work when so many people are working at wages below that level.

(d) Operation of manpower training and employment program.-- Your committee has previously expressed its dissatisfaction with the operation of the present Work Incentive Program. It has been hoped that the Departments of Labor and Health, Education and Welfare could effectively coordinate the admittedly complex operation of referring welfare recipients, training them and supplying them with necessary supportive services, and placing them in employment. Experience has shown, however, that in most jurisdictions the split responsibility and the resulting compounding of bureaucracy has greatly reduced the effectiveness of the program. Therefore, in the full realization that there must be more centralization of responsibilty if a large-scale work and training program is to succeed, your committee's bill would make a number of fundamental changes in the program. Along with the organizational changes which will be described in the following section, the bill provides for 225,000 training opportunities (of which 75,000 will be for upgrading adult family members who are working full-time), in addition to the 187,000 training opportunities now in the WIN program which would be available to the Opportunities for Families program.

(1) Federalizing the WIN program-- Federal responsibilities for manpower programs. The Secretary of Labor would be required to use a broad array of manpower programs and approaches in making recipients self-supporting. Such authority and responsibility under the new program is clearly lodged with the Secretary of Labor, not in an office of a State or local government. The Secretary could never be limited in carrying out his responsibilities by decisions made at those levels. While the WIN program has helped some recipients to become independent, it was a mistake to rely solely on State agencies in the administration of the program. For under those circumstances it is not possible to hold the Secretary of Labor entirely

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responsible for the results. Under the bill, however, this responsibility could not be avoided.

Your committee would give the Secretary of Labor the authority to administer the program in whatever manner will achieve the greatest results in reducing dependency. If he believes a particular State's employment service is the most effective instrument, he is authorized to use it. But first he must satisfy himself that that agency or any other non-Federal agency can do the job and achieve the ***5152** necessary results. If no agency is available that meets his standards of performance the Secretary should administer the program directly.

Whenever non-Federal agencies are used, your committee expects that a sufficient Federal presence will be maintained in the operation of the program to guarantee a high level of quality and efficiency. If the Secretary of Labor decided to use a non-Federal agency, he would have the full authority to specify whatever is required to assure efficient administration and program success through the provisions of the contract with such agency. When selecting a State or local instrumentality to act as his agent, the Department of Labor should be assured that offices are kept open such hours as are necessary to service those beneficiaries who are working as well as the unemployed.

(2) Provision of child care and supportive services by Department of Labor. Child Care: The work requirement and manpower services program will succeed or fail, depending on whether sufficient child care opportunities can be created. The experience with the present WIN program has shown clearly the importance of child care services in enabling mothers to undertake employment and training. Child care under present law has been inadequate, with the result that many AFDC mothers who might have moved toward economic independence have been unable to do so because of the lack of adequate child care arrangements for their children. Statistics provided by the Department of Health, Education, and Welfare show that significant numbers of mothers have been deterred from participating in the WIN program solely because of the lack of child care. Others have been enrolled but have had to drop out because of the uncertain nature and quality of their child care arrangements.

Many of the mothers who are now receiving assistance under the AFDC program have both the desire and the potential to move into employment. A recent study by the Department of HEW indicated that the proportion of AFDC women with high employment potential increased from 25.3 per cent in 1961 to 44.5 percent in 1968. Thus, it is reasonable to expect that almost half of the AFDC mothers can be moved into regular employment, with training, child care, and concentrated employment efforts. The report stated that 'as the AFDC caseload grew ever larger between 1961 and 1968, recipients were more and more women who had stronger educational and occupational backgrounds, that is, high employment potential.' However, the report also notes that over 80 percent of the women reportedly could not take jobs because they had children under age eight at home, and more than 50 percent lacked child care facilities.

Your committee recognizes that if the mothers who are enrolled in the new program are in fact to be helped toward moving off welfare, and if their children are to be helped to break out of the welfare cycle, it is essential that the availability of a wide range of child care services be vastly expanded. The need is for both pre-school and school-age services, with combinations of these services necessary for many mothers. Based on a 1969 survey of AFDC mothers, the Auerbach Corporation in its report on child care services under WIN stated:

Of the mothers on AFDC, over eighty percent have some combination of school age and pre-school children for whom some care is probably required. Fewer than fifty percent of these households have only pre-school children. Out ***5153** of the total of one and one-half million AFDC households, only 431,800 have preschool children exclusively; another 615,600 have school age children exclusively; and 548,400 have some combination of both school age and pre-school age children. . . . These figures indicate that the problem for the potential WIN population is not only for day care for pre-schoolers, but rather for some arrangement to take care of children before and after classes, or of some combination of service for both pre-schoolers and school age children.

It is clear that present law provisions for child care services are not adequate to meet the expanded need under the new program. More funds are needed, and a greater flexibility in developing services must be provided. As described later in this report, your committee's bill contains a number of provisions which will promote the child care services needed in support of the employment and training provisions of the bill. Perhaps most importantly, however, your committee's bill centers the responsibility for providing child care services to mothers in work or training on the Secretary of Labor. In this way, it is expected that the necessary coordination of manpower services and child care services will be achieved. The Secretary of

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Labor will have both authority and funds to purchase needed child care. It is intended that whenever possible he will use facilities developed by the Secretary of Health, Education, and Welfare, as described later in the report. However, when such facilities are not available, it will be the responsibility of the Secretary of Labor to secure child care through other sources. Your committee does not intend that the lack of child care will be cited as an impediment to the success of the program.

The Secretary of Labor may purchase child care directly through contracts with public or non-profit agencies. He may buy child care from private, profit-making enterprises. He may enter into contracts with school systems to supply after-school child care for youth of school age. He may operate, through his manpower agencies, a system whereby seekers of child care are brought together with persons who would like employment through caring for children.

The Secretary could make considerable use of a voucher system, under which the mother can have maximum choice in selecting a child care facility.

When the mother moves from training into employment (or goes directly into employment), rather than the Secretary paying for required child care, the mother would be required to pay for the care out of her earnings, if her earnings were substantial enough, and then get credit for the expenditure by deducting the cost from the earnings which would otherwise be used to reduce family benefits.

It is expected, therefore, that funds earmarked for child care slots will be used primarily to pay for child care when the mother is in training, while the earnings disregard provision will be used when the mother is working. The effect of this latter provision is to increase the child care support provisions well beyond that which could be achieved by direct purchase of care.

In cooperation with HEW, the Department of Labor will arrange for the training of recipients for jobs in child care facilities.

During the first year a total of $750 million would be authorized for child care, including $50 million for alteration, remodeling, and construction to create new facilities. The WIN day care authorization would be repealed. This authorization would support 875,000 child ***5154** care slots of which 291,000 would be for pre-school age children and 584,000 for school-age children.

Your committee believes that this authorization would provide for sufficient child care service to support the employment and training openings which are proposed under the bill in the first year. It has also taken into consideration the testimony of the Administration that this is the maximum expansion in services which could be achieved in that period of time. However, your committee fully expects that every effort will be made in future years to expand services as rapidly as is necessary and possible. For this reason, no specific authorization beyond the first year is included in the bill.

The bill provides that 50 percent of funds available to the Department of Labor would be allocated among the States on the basis of the number of mothers registered under the program.

Supportive Services.-- The failure to provide necessary health and other supportive services has been particularly damaging to the effective operation of the WIN program in many States. The lack of medical examinations, the lack of ability to remedy minor health problems, and the lack of counseling services which might solve serious family problems all lead to unnecessary and wasteful terminations of participation in training or employment. In all too many cases, the State employment agency and the welfare or health agency which is supposed to supply the required services have been unable to work out an effective working arrangement. Therefore, your committee has concluded that the Department of Labor should have the necessary authority and resources to secure needed supportive services. Such services should have a direct relationship to improving employability and increasing retention in training programs and employment. Wherever possible, these supportive services should be purchased from existing sources; your committee does not intend that the Department of Labor establish new sources of services unless they are not otherwise available.

The Secretary of Labor would be required to offer family planning services to all appropriate family members and would be required to furnish such services when requested.

Training expenses.-- Another related problem of existing law has been reimbursement for training expenses which must

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come from the State welfare agencies. This arrangement has often resulted in delayed payments, multiple checks, and general inconvenience to the trainee which have had an adverse effect on his attitude toward the program. The Auerbach Corp. reported:

The allowances the welfare departments grant clients to cover their expenses incurred while participating in the WIN program vary greatly from State to State. In some States, expenses are simply inadequate. At the other extreme, some States, besides furnishing funds for child care, transportation and lunch, provide a welfare incentive which may be used by the client as he wishes; to purchase clothes, to spend on easily prepared foods, etc.

In those projects where welfare funds were inadequate to cover costs, caseworkers frequently stated that the client received a WIN incentive allowance which could be used for these expenses. Thus, in those States where welfare allotments are low, the WIN incentive is not actually functioning as an additional supplement, but is being used to cover expenses incurred from participating in the program.

***5155** Under your committee's bill, the Department of Labor on a uniform basis could reimburse the trainee for reasonably necessary additional expenses directly related to his participation in training, such as transportation, special clothes, and supplies needed for the training.

(3) Work-oriented manpower program. It is assumed by your committee that large numbers of recipients can be placed directly in jobs, and that extensive 'employability' plans will be necessary only for more difficult cases. If a person is job ready, then the employability plan would consist simply of a referral to an existing job.

The committee's bill authorizes all known manpower techniques to develop employability, including counseling, testing, coaching, job orientation, institutional and on-the-job training, work experience skill upgrading, relocation assistance, job placement, and follow-up services. An authorization of $540 million would be provided for the first year for such services.

Your committee has been concerned with the undue emphasis on basic education and other institutional training which exists in WIN and which has also been a characteristic of other job training programs for welfare recipients. It is hoped, therefore, that with the increase in the Secretary of Labor's direct authority to carry out the intent of Congress, program components directly related to work-- such as on-the-job training-- will be utilized more frequently and effectively. At the present time, only 1,000 recipients are in on-the-job training slots. Moreover, your committee is increasingly concerned with the growth of the number of individuals who have completed their training but are in 'holding' because they cannot be placed in jobs.

The following table shows both a decreasing number of current WIN trainees in actual jobs and an increasing number of individuals who have completed training but for whom no job has been found.

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The difficult task of job development to provide employment to recipients in the private sector must be pursued more diligently by the Department of Labor and by private industry itself. But your committee believes that a program of public service employment must also be instituted if any substantial progress is going to be made in providing jobs for recipients under prevailing economic conditions. This new program is described in the following section.

(4) Public service employment. Since the **Social Security Amendments** of 1967, your committee has strongly supported the provision of public service jobs for those welfare recipients for whom job training is not appropriate or those individuals who have completed training but for whom no private sector jobs are currently available. The bill once again emphasizes the necessity of this type of program, but ***5156** eliminates the financing arrangements of the WIN 'special work' projects which the Department of Labor maintains have inhibited the implementation of the provision. It is hoped that the traditional antipathy of the Department of Labor to this type of activity will have been dissipated by the realities of the present job market and that the program will be carried out with vigor and imagination.

The creation of a public service employment program assures that more recipients will be required to take a job, not just accept benefits. At the same time it has the advantages of developing and maintaining the work skills of the unemployed, of utilizing labor otherwise idle in projects that are in the public interest, and of giving assistance to hard pressed State and local governments which are now unable to meet all of the critical community services demanded by their citizens.

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Your committee's bill would authorize the Secretary of Labor to provide for public service employment programs through grants to or contracts with public or nonprofit private agencies or organizations.

It is not intended that these jobs be used on a long-term, permanent basis to support individual recipients. They should be viewed to the extent possible, considering existing economic conditions, as providing transitional employment that will help prepare individuals for regular, unsubsidized jobs when they are available.

Your committee's bill contemplates public service employment opportunities for 200,000 people during the first full year of operation, at a cost of $800 million. On a net basis, subtracting direct savings in benefit payments, the cost would be about $500 million. The amount authorized for the first year is $800 million; amounts for later years are unstated so that a review of the need for such jobs can be assessed annually.

Your committee would require the general wage policy for public service employment jobs as would govern referral to regular jobs. However, no jobs would be created below the Federal minimum wage level, even if the Federal minimum wage law were not applicable to those specific jobs. The prevailing rate for such public work or work of a similar nature would apply if it were higher than the Federal minimum.

The proposed public service employment program would have safeguards against displacing regular workers. It would also contain incentives for employers to move participants on to regular payrolls by reducing the Federal matching share of any individual's enrollment progressively during a three year period. The Federal government's share of the cost of providing such employment could not exceed 100% during the first year, 75% during the second year, and 50% during the third and final year. To further assure referral to regular jobs or training opportunities, the Secretary of Labor would be required to review each individual case at least every six months to see if such a transition could be made.

In order that the Secretary of Labor will have the broadest access to non-subsidized jobs, all State and local agencies supported in any way by Federal funds would be required to list their job vacancies with the Secretary of Labor. This would assure that the Secretary had knowledge of as many job openings as possible in which he might be able to place a beneficiary.

Your committee does believe, however, that public agencies supported by Federal funds should be expected to do their share of hiring ***5157** beneficiaries when they do have vacancies. Under your committee's bill, these agencies would be required to establish goals for hiring beneficiaries but an agency would not be required to hire every individual who is referred. It is not the intent that such agencies be forced to hire unqualified people.

In addition, your committee believes that wherever possible, recipients should be considered as a hiring source for regular Federal jobs, where they could-- with training where necessary-- qualify for these jobs.

(5) Priorities for training. It is the intent of your committee that as large a number of registrants as possible be placed in available jobs or training. It is recognized, however, that it will not be possible to serve all registrants during the first year. It will be necessary to set priorities. In setting such priorities the Secretary should have the objective of maximizing Federal savings in benefit costs by selecting people for training with a realistic view of job opportunities actually available in the local labor market. Also, a specific priority for teen-age mothers has been written into the bill. Your committee is convinced that the young teenage mother who volunteers for this program should have the highest priority because she is the most likely to benefit from the training and thus escape from being condemned to a life on welfare. If at all possible, such a young mother should be helped to finish high school; and high school training would be the most appropriate the Secretary could arrange for her under most circumstances. Regular school attendance would be required in such instances.

(6) Allowances for individuals undergoing training. In some instances training incentive allowances have been unfair to WIN participants in that a person assigned to a manpower development and training (MDTA) class might be sitting beside a MDTA enrollee who was receiving a substantially higher allowance than is allowable under WIN. Your committee's bill would continue the WIN allowance of $30 per month for each individual who is a member of a family and is participating in manpower training, but if his allowance under the MDTA program would be more than $30 higher than the Federal payments plus any State or local supplemental payment, the incentive allowance to the trainee would be the difference between the two

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allowances.

Under the Manpower Development and Training Act, the basic allowance is computed on the basis of the average weekly gross unemployment compensation payment (including allowances for dependents) for a week of total unemployment in the State making such payments during the most recent ********** period for which such data are available. This amount may be increased by up to $10, and in addition $5 a week for each dependent over two up to a maximum of four additional dependents. There are special provisions to deal with the situation in which an individual's unemployment compensation benefits would exceed his training allowance.

(7) Relocation services. Your committee is somewhat disappointed with the achievements in relocating WIN recipients under existing law. The Department of Labor reports that about 650 families have been moved to new areas under its provisions. In the administration of such services under the new program your committee recognizes that persons should be relocated only when regular employment can be found for them in another area. While the employment would not ***5158** necessarily have to be at a wage that would immediately remove a family from benefits in order to justify the relocation expense, neither would it be desirable to create such an expense unless there was an assurance of a substantial, lasting job at the new location.

(8) Summary of resources available in first year. The following table summarizes the resources which would be available, primarily to the Secretary of Labor, in the first year of the program under the bill (the figures include new resources as well as those which would have been available under present programs):

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3. Family assistance plan

According to Administration estimates, approximately 2.6 million families (including 13.9 million people) would be registered by the Department of Labor in the Opportunities for Families program during fiscal year 1973. These would be the families with one or more members who are determined to be available for work. All other eligible families, 1.4 million families (including 5.5 million people) would be enrolled by the Department of Health, Education, and Welfare in the Family Assistance Plan.

The Family Assistance Plan would cover the female-headed families with children under age 3 (under age 6 until 1974), or families in which the only adult members are incapacitated or otherwise exempt from registering under the Opportunities for Families program. Those who voluntarily register for work and training would automatically be placed under the Opportunities for Families program.

Although families under the HEW-administered program of family assistance would, by definition, be composed entirely of persons exempt from the bill's regular work and training requirements, incapacitated individuals in such families would be referred to the State vocational rehabilitation agencies, and would be required to participate in any program of vocational rehabilitation which such agencies might find appropriate for them. The State would be reimbursed by the Secretary of Health, Education, and Welfare for the costs of providing these services and making determinations of incapacity.

An incentive allowance of $30 per month would be paid to family assistance beneficiaries undertaking vocational rehabilitation together with allowances for transportation and other expenses. In addition, child care services necessary to enable recipients to take vocational rehabilitation training would be made available by the Secretary of Health, Education, and Welfare.

The Secretary of Health, Education, and Welfare would be required to offer family planning services to all appropriate family members and would be required to furnish such services when requested.

The Department of HEW is expected to utilize necessary portions of its authorized appropriations for vocational rehabilitation services, supportive services, and family planning services.

***5159** 4. Federal benefit payments

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Although the responsibility for assistance to needy families would be appropriately divided between the Department of Labor (for families with at least one employable member) and the Department of Health, Education, and Welfare (for families with no employable member), your committee's bill establishes a single basic structure of eligibility requirements and benefit levels applicable to both groups. In order to provide uniformity of administration under this new national system of family benefits, the Secretaries of Labor and Health, Education, and Welfare would jointly establish procedures, policies, and interpretations of law.

(a) Eligibility for and amount of benefits.-- (1) Eligibility: Each family with children under 18 (or under 22 if regularly attending school) whose income (other than excluded income) is less than $800 per year for each of the first two family members, $400 each for the next three members, $300 each for the next two members, and $200 per year for the next member, and whose resources (other than those excluded-- the home, the household goods, personal effects, etc.) are $1,500 or less would be eligible to receive a benefit.

A family headed by a full-time college or university student would not be eligible for benefits.

Under your committee's bill, payments would be made to all families with children who are in need as defined by the above specified income and resource limits. Included would be families headed by a fully employed father which are currently ineligible for AFDC benefits in all States and families headed by an unemployed or only partially employed father which are now eligible for AFDC in only 24 States. Thus, the bill eliminates one of the most frequently heard and most telling criticisms of the present welfare system, namely, that it places a premium on the broken family by denying assistance if the father remains in the home. In addition, your committee's bill corrects a problem situation existing in those States which do provide AFDC to families of unemployed or partially employed men. Under current law, it can be financially disadvantageous for such men to take a full-time job since full-time employment, even for very low wages, will make them ineligible for further assistance while part-time employment does not. Under the bill, assistance would continue for those who become fully employed unless their earnings are high enough to make the family ineligible.

(2) Benefits: Assistance would be payable at the rate of $800 per year for each of the first two family members, $400 each for the next three members, $300 each for the next two members, plus $200 per year for the next family member, and would be reduced by non-excluded income. (If the family benefit is less than $10 a month, the benefit would not be payable.)

A family of four with no income counted to reduce benefits would be eligible for a benefit of $2,400. The maximum benefit for any family (eight members or more) would be $3,600. A family with just two persons would be eligible for $1,600.

These benefit amounts would be reduced by the amount of any income available to the family from other sources except that a portion of earnings (and limited amounts of other types of income) would not be counted. The first $720 of earned income each year would not be ***5160** used to reduce the family's benefit nor would one-third of any earned income above $720.

EXAMPLES OF FAMILY PAYMENTS [6]

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In 22 States the Federal benefit level would mean an increase in the largest amounts now paid to families of four with no other income.

BENEFIT LEVEL CURRENTLY UNDER $2,400

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A standard Federal level would tend to inhibit whatever motivation people might have to move from an area with low welfare payments to an urban center with seemingly higher payment levels. In fact, it is possible that the standard level of payment provided in these programs plus the nationally uniform administrative structure contemplated might very well attract some needy families back to rural areas from urban centers where they now live.

(3) Special limits on gross income: The bill requires the Secretary to prescribe in regulations the circumstances under which gross income from a trade or business (including farming) would be large enough to preclude eligibility for benefits. (Gross

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income would be defined as it is in Chapter 1 of the Internal Revenue Code.) Without any restriction, it might be possible for some families with substantial gross incomes, but little or no net profit to resources, to qualify for benefits.

Your committee believes that earnings from farming and certain other businesses require special treatment. People in such businesses may have substantial gross incomes during a year but net earnings small enough to qualify themselves and their families for payments. The net earnings of a family whose income is derived from a business ***5161** can fluctuate considerably from year to year. The net earnings may be high in one year and very low the next year. One reason for this is that a businessman has considerable control over the amount of his net earnings; he may choose the time to incur a number of business expenses in order to increase or decrease his net earnings in any given year.

Also the amount of net earnings depends to a large extent on business expenses, which are deductible for income tax purposes. Depreciation allowances and other income tax deductions, for example, reduce the net earnings of a businessman without actually reducing his spendable income.

In the opinion of your committee it would be inappropriate to permit people who have a large gross income to get payments when they have a substantial cash flow from which they can live in moderate or better-than-moderate circumstances.

(4) Drug and alcohol abuse: Your committee would also exclude from benefit eligibility family members who are determined by the Secretary to be incapacitated because of drug abuse or alcoholism and who refuse to take remedial treatment. These people would ordinarily be those required to register for work or training, but are not so required because of drug or alcohol abuse. Appropriate treatment would be furnished at government expense at an approved institution or facility and the patient would be expected to comply with all facets of such treatment.

The Secretaries of Labor and of Health, Education, and Welfare are directed to provide for the monitoring and testing of all such individuals who are in the Federal benefits program and determine how these requirements contribute toward the improvement of these individuals, their families, and the movement of the families from the benefit rolls. The Secretary of Health, Education, and Welfare is directed to include information on the activities of both Departments in his annual report to the Congress.

(5) Application for other benefits required: Since family assistance payments are to be made only to families to the extent they are actually in need, your committee's bill requires that families apply for any other benefit or payment due them. If any family member within 30 days fails to take all steps necessary to obtain unemployment benefits, old-age, survivors, and disability insurance, or any other payments such as annuity, veterans' pension, workmen's compensation, or railroad retirement benefit for which he is eligible, the family would not be eligible for assistance.

(6) Definition of income: Income for purposes of your committee's bill includes both earned and unearned income. Earned income is defined generally by reference to the definition of earnings for earnings test purposes under the old-age, survivors, and disability insurance (OASDI) program and includes both wages and self-employment income.

Net earnings from self-employment are defined in the bill by reference to the present definition applicable to the OASDI program with the exception of certain provisions of that definition which your committee believes inappropriate for this program, such as the special provision under which a farmer's net income may be presumed to be a given percent of his gross income.

Income which does not fall within the bill's definition of earned income would be considered unearned. However, certain forms of remuneration ***5162** which are specifically excluded from the OASDI definition of earnings are not to be considered as income. For example, contributions by an employer into a health insurance or retirement fund for his employees is a form of remuneration, but such contributions would not be considered income-- earned or unearned-- for the individual employees.

The kinds of income which would be considered unearned include annuities, prizes and awards, proceeds of life insurance not needed for last illness and burial (with a maximum of $1,500), gifts, support, inheritances, grants, dividends, interest payments, as well as benefits from all other public and private pension, disability, or unemployment programs.

The distinction between earned and unearned income is significant because of the fact that special deductions would be

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applied to earned income which would not be applied to unearned income. (See provisions described below.)

(7) Exclusions from income: All income, earned or unearned, in cash or in kind, would be deducted dollar for dollar from family benefits otherwise payable unless it is specifically excluded under the following provisions:

First, your committee's bill would provide, subject to such limitations as the Secretary may prescribed, for exclusion of the earned income of a child who is regularly attending school. Existing law, in addition to excluding the earned income of a child who is a full-time student, also excludes the earned income of a part-time student with a less than full-time job. Your committee continues to believe that special treatment of earnings of students is warranted so that these earnings may help to finance school attendance and offer tangible rewards that encourage work habits.

Second, in determining income there would be excluded unearned income of $60 or less a quarter and (in addition) earned income of $30 or less a quarter, provided that such earned and unearned income is received infrequently or irregularly. Your committee believes that this provision would facilitate administration by making it unnecessary to adjust benefits every time an individual received a small cash job. Your committee believes that it is reasonable to provide a higher exemption, $60, for unearned income than for earnings, since the bill contains additional provisions for the exclusion of earnings that are not covered by this provision. Even though certain earnings or income might not be counted against benefits under this provision, family members would be expected to report all income.

Third, your committee's bill would provide for the exclusion of an amount of earned income of a family member equal to all or part (subject to the limits described below) of the cost incurred in obtaining child care which is necessary for securing or continuing employment. The schedule under which the cost of child care would be deducted would be made consistent with the fee schedule established by both Secretaries for child care provided directly. The intent is that the effective cost of child care for all those entitled to it would vary according to income, but would be the same regardless of whether the participant was affected by the income disregard provision or had care provided directly. The Secretary of Labor could require a working mother enrolled under the Opportunities for Families program to purchase child care herself where it is available and then use the earnings disregard provision to pay for it. Child care costs which could be disregarded ***5163** under this provision could not exceed the going rate in the community in order to avoid situations where the cost of care provided by friends and relatives would be inflated. Your committee believes that, since child care is frequently costly, failure to exclude the cost of this care from income in determining the amount of the assistance payment might well create a disincentive, if not a total barrier, to employment on the part of some mothers. Under other provisions in the bill the Secretary of Health, Education, and Welfare and the Secretary of Labor are required to assure that child care is available for mothers who are in training.

Your committee's bill would also provide a limit for the combined total earned income exclusion for a family with respect to these three items-- student earnings, irregular earnings and child care costs-- of $2,000 for a family of up to four members, with an increase of $200 for each additional family member up to an absolute limit of $3,000. This provision would serve to control exclusions and thereby prevent situations under which families with very high incomes could be found eligible for some payments, because several of the income exclusions apply to several family members. For example, without such a limitation a family of four including 3 students, each having part-time earnings of $40 a week, could qualify for assistance even if its total annual income exceeded $10,000.

Fourth, the bill would encourage work by disregarding certain amounts and proportions of earned income. Under present AFDC programs, each State is required to exclude, in determining the amount of assistance payable to an eligible family, the first $30 of its total earned income each month plus one-third of earnings above that $30. (This exclusion does not apply in determining a family's initial eligibility.) The $30 and one-third exclusion is made in addition to other exclusions such as those for child care and other work expenses, and the earnings of children in school.

Your committee's bill would eliminate the open-ended work expense exclusion and, in its place, would increase the flat earnings exclusion by $30 per month so that on an annual basis the amount of earnings excluded from consideration would be $720 plus one-third of earnings above $720. This exclusion would apply to that portion of the family's earnings remaining after the exclusions allowable for child care, student earnings, and irregular income.

Thus, your committee's bill allows recipients to keep, in addition to their assistance payments, an amount of earnings designed to meet the costs of going to work plus certain additional amounts which will make it financially advantageous for

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family members to seek, obtain, and remain in employment. At the same time, the bill eliminates the situation under present law in which exclusion can be piled upon exclusion, with virtually no limit, with the result that families with very high incomes can still qualify for welfare payments.

The bill also makes the earned income exclusions applicable in determining initial eligibility for benefits. This corrects an inequitable situation under present law in which families with the same income and resources are treated differently.

Fifth, your committee's bill would provide that other assistance (not including veterans' pensions) provided on a basis of need by a public or private agency (a private agency or organization being described as one that is exempt from taxation under Section 501(c)(3) or (4) of the Internal Revenue Code) would have no effect on the amount of the ***5164** family assistance payment. Your committee believes that this policy is necessary in order to permit efforts on behalf of the poor by private organizations and by State and local governments, including Indian tribes. Supplemental payments made by a State or local government could not undermine the earnings disregard provisions if such payments are to be disregarded under this provision.

Counting veterans payments against the benefits continues a long-standing practice in welfare, and thus does not interfere with the veteran program's benefit structure.

Sixth, the bill would exclude from income the $30 per month allowances provided by the Secretary of Labor (and up to $30 a month training allowances which could be provided by the State also if it wished) to individuals undergoing training. If the benefits were reduced on account of receipt of these allowances, their purpose, which is to provide an incentive for training, would be nullified. The $30 training incentive allowances for individuals, undergoing vocational rehabilitation would also be excluded. Allowances provided for transportation and other expenses in connection with rehabilitation and training would also be exempt.

Seventh, the bill would exclude from consideration as income any portion of a grant, scholarship, or fellowship received for use in paying the costs of tuition and fees at any educational institution. Any portion of such payments which are intended for general living expenses, however, would be included as unearned income.

Eighth, the bill would provide for the exclusion of home produce of a family used by the household for its own consumption. This provision is necessary to avoid the administrative difficulties of determining the value of such home produce. There is generally very little economic advantage resulting from home produce raised and consumed at home.

Ninth, one-third of support and alimony payments would be excluded from income. Your committee believes that a family would have little incentive to assist in obtaining support from an absent parent if all such income were counted to reduce assistance payments.

Tenth, the bill would provide for the exclusion from income of amounts received for furnishing foster care to an unrelated child placed in the home by a licensed or approved child care or child placement agency. Your committee believes that by excluding such amounts a possible disincentive for a family getting assistance to act as a foster family would be avoided. Moreover, it would seem unfair to reduce the benefit of low income families simply because they provide homes for foster children.

The following examples illustrate how earned and unearned income would be taken into account in specific situations (annual amounts are used):

Family A

Mother, two small children, one son aged 19 in college-- total of four. All income received for the year was:

1. Two cash gifts, $25 each, at Christmas and the beginning of the school year in September, from a relative.

2. Part-time earnings by the son, totaling $900 for the year.

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3. $900 support payments for the children from the divorced father.

***5165** Determination of family payment

1. The gifts and the student earnings would be excluded under the bill.

2. One-third, or $300 of the child support payment would be excluded from income, leaving $600.

3. The family payment of $2,400 would be reduced by $600; the family would receive $1,800 in assistance payments for the year and its total income would be $3,650.

Family B

Mother, father, six children-- total of 8. All income received for the year was:

1. Father worked part-time for 6 months, with earnings of $600.

2. Father in vocational training course provided for Department of Labor paid $30 training allowance for six months.

3. Two older children-- not students-- earned $2,730.

Determination of family payment

1. The earnings of the father and children would be combined. The total of $3,330 would be reduced by $720, and one-third, leaving a balance of $1,740 in countable income.

2. The father's training allowance would be excluded from income.

3. The family payment of $3,600 would be reduced by $1,740; this eight member family would receive $1,860 in assistance payments for the year and its total dollar income from all sources would be $5,370.

(8) Period for determination of eligibility for and amount of benefits: Your committee gave careful consideration to the choice of an appropriate period for determining eligibility for and amount of benefits, because the particular system chosen has implications for both equitable treatment of families and for total program costs.

The bill would provide for the use of a calendar quarter accounting and benefit period rather than a shorter period, such as a month, or a longer period, such as a year. One important advantage of the quarterly accounting period is that it would facilitate verification of earnings through the use of social security records, since social security earnings are reported on a quarterly basis. Records of monthly earnings are not available from either the Social Security Administration or the Internal Revenue Service. Consideration was given to the use of an annual accounting period but it was decided that this approach would not be sufficiently responsive to changes in earnings levels; in particular, a change to high earnings resulting from a full-time job would not be reflected in decreased benefits for a substantial period of time.

Your committee's bill provides that a family's eligibility for benefits, and the amount of its benefits, would be tentatively determined for each calendar quarter on the basis of the best estimates of income for that quarter and income received in the most recent three quarters. Monthly benefits would be paid during the quarter in most cases based on these estimates. The estimates could be modified as circumstances change i.e., family members start or stop work, or the composition ***5166** of the family changes. Changes in current monthly payment rates would be made to reflect changes in estimates. Actual benefits would be determined after the end of the quarter on the basis of income actually received in that quarter and income from the previous three quarters.

Whenever an application for family assistance payments is made, the applicant would be required to furnish information and

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estimates of all income for the past three calendar quarters. He would also furnish the best available estimate of income for the current calendar quarter which the Secretary would take into account in making the payment for the quarter. For both entitlement and payment purposes, an application filed on any day of the month would be deemed effective with the first day of such month.

When a family has no non-excluded income (hereafter called countable income) during the current quarter and the three prior quarters, it will be entitled to its maximum quarterly benefit in the current quarter. If the family did have countable income in the current quarter (but none in the prior three quarters), the maximum allowable quarterly benefit would be reduced by that amount.

For example, Family A (4 people) has no income in the past three quarters, and none estimated in the current quarter. It will be paid a Federal benefit of $600 for the current quarter.

Family B (4 people) has no countable income in the past three quarters, but has earnings of $780 in the current quarter. After applying income disregards ($720 per year, or $180 per quarter, plus one-third) to the $780, the family has $400 in countable income. That $400 is subtracted from the maximum benefit of $600, giving the family a benefit of $200 in the current quarter. The total gross income of the family for the quarter would be:

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Family C (4 people) has no income in the past three quarters, but has earnings of $1,305 in the current quarter, $750 of which is countable, after exclusions. The family will not be entitled to any Federal benefit for the current quarter since countable income-- $750-- exceeds the maximum benefit payable ($600).

Although accounting under your committee's bill is on a quarterly basis, families with irregular incomes because of seasonal employment or other factors cannot get payments for periods of low income if their annual incomes are high. When countable income in any of the three prior quarters exceeds the maximum quarterly benefit for the family for the quarter involved and has not been previously used to offset benefits, such excess must be added to non-excluded earnings in the current quarter and the total is then applied to reduce benefits in the current quarter. The excess from the current quarter is counted first, then the most recent quarter and so on.

For example, Family D (4 people) had no income in the earlier two of the preceding three quarters, but did have countable income of $750 in the immediately preceding quarter. Since $750 exceeds the maximum quarterly benefit of $600 for that quarter by $150, the excess of $150 is carried forward to the current quarter. The family has no income in the current quarter, so its maximum possible benefit of $600 is reduced by the $150 carryover and it gets a $450 payment.

***5167** Family E (4 people) had $600 of countable income in the third preceding quarter, $1,100 in the second preceding quarter, $300 in the immediately preceding quarter and no income at all in the current quarter. With a family of 4, $600 represents the amount of countable earnings that would exactly offset any assistance payment in each quarter. Thus, the $600 countable earnings in the third preceding quarter would result in no 'carryover.' The $1,100 in the second preceding quarter results in a carryover of $500 (the $600 benefit amount is subtracted from the $1,100 income amount.) In the first preceding quarter, $300 of the $500 carry-over from the second quarter is applied to eliminate benefit payments (the $300 is added to the $300 in countable income in the first preceding quarter). This leaves $200 which now is applied to the current quarter. The family's benefit of $600 in the current quarter is, therefore, reduced by $200 and it receives $400.

Generally, the results of these provisions are to treat families which have seasonal employment the same as those with the same total of income spread evenly over the year and also to have benefits paid over a year fluctuate with variations in income.

Your committee carefully studied alternative approaches for determining the family benefit. The above system is believed to be an easily understood, easily applied, and conservative method. It provides an even handed approach to various family situations: the ones where the worker is just going into employment, just leaving employment, or has very irregular or seasonal employment. It is conservative in that a 4-quarter period is taken into account in all cases and, thus the possibility of scheduling the receipt of income or contriving an earnings pattern would yield no advantages. It is completely compatible with the method of estimating the cost of the family programs.

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Once a family becomes eligible for assistance, it will be expected to keep and make available documentary evidence of its quarterly income. At the time of initial application, however, the family may not have such evidence for the preceding quarters. In such cases, the income for those quarters will be determined by the Secretary on the basis of the best evidence that is available.

A family receiving assistance will be required to report immediately any change in income or family composition which materially affects eligibility or benefit amounts. When notices of such changes are submitted to the Secretary a revised determination of eligibility and benefit amounts would be made at once.

Any overpayment or underpayment of benefits resulting from the above rules will be reflected as soon as administratively feasible in future benefit payments or other action, such as a request for refund.

Each family receiving benefits will also be required to submit a report on income and family status within 30 days after each quarter. This report will usually be sent by mail and will include information needed to determine eligibility and final benefit amounts for the quarter. If the report were not received within 30 days, assistance payments would be stopped until the report was received. (A late report would not, however, result in the permanent loss of benefits.)

In order to assure complete and prompt reporting of events which would change benefits during a calendar quarter, the willful failure to report such changes without good cause would result in a penalty of $25 to be assessed for the first such failure, $50 for the second, and $100 for the third or subsequent failures. These penalties follow the ***5168** same kind of provisions in title II for cash social security benefits except that the penalties are in specific dollar amounts rather than monthly benefits.

In summary, these provisions should enable the Secretary to establish an effective system for determining entitlement to family assistance payments, for computing quarterly benefits, and for helping to assure the integrity of the program.

(9) Resources: Under present law there is a wide variation in the manner in which resources, such as a person's home, are treated under State public assistance programs. Many States exclude the home as a resource while others consider the home only if its value exceeds a specified amount. Household goods and personal effects are generally excluded under present programs. Your committee believes that a family's home, household goods, and personal effects of reasonable value, as well as other property which is essential to a family's means of self-support, should not be considered resources and the bill so provides. Since one of the purposes of the bill is to help families take their place as productive members of society, it seems appropriate to avoid disincentives to home ownership and to the accumulation of some personal effects.

The bill provides for the Secretary to establish by regulation reasonable limits on the value of the home, household goods, and personal effects that may be excluded. While generally following presently permitted practices, these regulations would permit the Secretary to deal with those situations wherein a family might seek to evade the resources limitation by converting otherwise includable assets into another form which is excludable. It would also permit the counting of items of substantial value, such as expensive jewelry. These regulations would, in general, follow present rules in the AFDC program but would not necessarily be as liberal as those now in existence where the Secretary finds existing provisions not to be consistent with the purposes of the bill. However, it would not be expected that every family's personal effects would be evaluated. Thus, where there is no reason to believe that such effects include anything of substantial value, the necessity to evaluate would be avoided. Statements on this point would be required of applicants for benefits.

The exclusion of resources essential to a family's means of self-support such as an automobile needed for purposes of employment, the tools of a tradesman, or the machinery of a farmer is, of course, also important from the standpoint of the objective of strengthening the family's capacity for self support. Your committee believes that where income producing property is not used as part of a trade or business, the value of such property should be excluded from the resources limitation only to the extent it is producing a reasonable return and the bill so provides. The exclusion would be based on a fixed percentage return, to be set forth in the regulations of the Secretary in order to permit adjustments for changing economic conditions. Property not used in the operation of a trade or business and which does not provide a reasonable return should clearly be included as resources.

Where a family has only a very limited amount of life insurance, such as might be designed to meet the immediate expenses

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which would be incurred in the event of death, it is inappropriate to look ***5169** upon such insurance as a resource available for family support. This is not, however, the case with respect to more extensive insurance holdings, which may have a substantial cash surrender or loan value. Accordingly, the bill provides that insurance policies will not be considered if all policies held by the family have a total value of $1,500 or less per person. If the face value of the family's insurance policies exceeds this amount, the cash value of the policies will be considered in determining whether the family's resources exceed the overall $1,500 limit.

Under the bill, property not excluded from resources would be subject to the $1,500 limitation on resources. Families with resources which are readily convertible will be expected to dispose of resources above the $1,500 limitation before they are considered eligible for assistance payments. Proceeds from the disposal of such resources would, of course, be expected to be used by the family for their support and counted as income, which would be considered in determining family eligibility for assistance and the payment amount.

The Secretary's regulations would be written so as to avoid the possibility that assets could be turned into real or personal property which would be excluded. For example, a substantial prize would have to be used to meet current expenses rather than converted into personal property. The disposal of certain other types of assets, such as buildings or land, would often require some time. Your committee's bill, therefore, would authorize the Secretary of Health, Education, and Welfare to prescribe time limits governing the disposition of various kinds of property and to make conditional assistance payments during the time allotted for the disposal of the property in question. Income received from the disposition of resources would be considered to have been received during the period when the family was receiving conditional assistance payments, and the family would be obliged to repay the resulting overpayments out of the proceeds of the disposition, subject to the conditions set forth in the provisions of the bill governing overpayments.

Your committee expects strict application of the law, particularly where families which apply for assistance have real property other than the residence. For example, if a family which owns the home and lot where it resides also owns a 40-acre tract of land, valued at $25,000, that tract should be sold and the proceeds used for the family's support before the family would be eligible for assistance. The Secretary would have discretion, as indicated above, in determining whether satisfactory efforts are made to dispose of property and in providing conditional assistance payments during the period of sale.

(b) Meaning of family and child.-- (1) Meaning of family. The presence of a child in the household would be the key to the definition of a family. When a family meets the income and resources tests, payments under the plan would be made for all members who are related by blood, marriage, or adoption, as long as they are living in the same residence and as long as at least one family member is under age 18, or under 22 if regularly attending school, and not married.

The bill would require that at least one child be in the care of or dependent upon another family member in order to qualify the family for benefits.

Your committee expects the Secretary to be alert to situations where families might deliberately split into two groups (residing, for example in nearby apartments) in order to obtain higher benefits under the ***5170** plan. The committee intends, where the Secretary finds that this has been done for such a purpose, that he rule that only one 'place of residence' is involved for the family and make payments as though both groups were members of one household.

Although generally family members must be living in the same place of residence in order to qualify as a family for benefit purposes, the bill provides that a parent (or the spouse of a parent) who is temporarily away from home for the purpose of engaging in or seeking employment (including military service) or self-employment, would nevertheless be considered to be living in the home where the child resides. Your committee believes that it is clearly reasonable to consider such an individual as a family member and to consider any income he may have as income to the family. If such a provision were not included temporary absence from the home could disqualify the parent as a family member, with the result that the absent individual's income would not automatically be considered income to the family. Moreover, without this provision a child who is away working or seeking work would be ineligible for benefits until the parent returned.

As indicated earlier, if the family head is an undergraduate or graduate student regularly attending school full-time, that family does not qualify under the program.

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Only families living in the United States would be eligible. At least one of the members must be a U.S. citizen or an alien lawfully admitted for permanent residence. Benefits would not be paid on behalf of any member of a family for any month in which he is outside the United States.

(2) Meaning of child: The bill defines a child as an individual who is under age 18 or under age 22 and a student regularly attending school who is neither married nor the head of the household. Your committee wants to make clear that an unborn child would not be included in the definition of a child. This will preclude the practice, now used in the AFDC program in some States, of finding that an unborn child does meet the definition, thereby establishing a 'family' even before the child is born.

(3) Determination of family relationships: Under your committee's bill determinations of relationships will be based on State law. This conforms to the general practice presently followed under public assistance programs, social security, and veterans' programs. The Secretary would have the authority to determine which State's law would be governing in particular cases in which a conflict of law arises. The Secretary would also have the authority to determine which of two laws of the same State would be most appropriate in determining the relationships in a particular family. The Secretary could not elect the law of one jurisdiction, the District of Columbia, for example, and apply that law to individuals who reside in other States.

(4) Income and resources of noncontributing individual: Your committee's bill would exclude from consideration in determining eligibility for and the amount of benefits, the income and resources of any individual which are not available to the rest of the family. An individual in the household whose income and resources are not so available would not be considered a family member and the benefit amount payable to the family would be computed without counting ***5171** him. However, this rule would not apply to parents (or their spouses) living in the same household since their income and resources should ordinarily be available to the family and since the exclusion of their income or resources might easily lead to abuses of the system. For example, if income were not imputed in the case of the father or stepfather who is living in the same household with the children, it would be extremely difficult to prove that the father of stepfather were actually contributing to the support and maintenance of the children if he should allege that he was not. Thus, under the bill the income and resources of a step-parent living in the household would in every case be included in determining a family's eligibility for benefits.

(5) Recipients of assistance to the aged, blind, and disabled ineligible: Your committee's bill continues the usual rule against payment of benefits under more than one public assistance plan by excluding from benefits under the family programs any individual who elects to receive aid under title XX, Assistance for the Aged, Blind, and Disabled. Under your committee's bill, such an individual and his income and resources would not be counted.

(c) Payments and procedures.-- The new assistance programs for families-- the Opportunities for Families program and the Family Assistance Plan-- which are established by your committee's bill will be much more tightly administered than the current AFDC program. For one thing, there will be more rigid identification and program validation techniques. For example, documentation of elements of eligibility will be required, and social security numbers and records will be utilized. The establishment of an effective Federal administrative mechanism will help to achieve tighter administration of the assistance programs. It is also necessary, however, to provide the Federal administering agency with the tools it needs to do the kind of job expected, and these tools are provided in the procedural sections of your committee's bill.

(1) Payment of benefits: It is the intent of your committee that payments would ordinarily be made (after determination of eligibility and registration for manpower training, and employment) to the head of the family on a monthly basis. To take account of diverse family situations and to facilitate administration, however, a provision in the bill would allow the Secretary to make payments or partial payments to other members of the family, or to other interested persons, or to an agency.

Where it appears that the interests of a family or family member (especially a child in such a family) would be best served thereby, your committee's bill provides that payments would be made to an agency or to a person other than a family member, who is interested in or concerned with the family's welfare.

If it appeared to the Secretary that the family's inability to manage funds would very likely continue indefinitely, he would attempt to secure the appointment of a legal guardian. Families protesting the protective payee action would be given an

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opportunity for a hearing. When a family member is considered able to manage the payments, there would be a return to regular payment status.

Payments under this provision could be made either as vendor payments to a person furnishing goods, services, or items to the family, or as payments to an interested and responsible relative. The family payment might be paid part to a family, or part to a vendor, part to an interested individual, or a combination of any of these.

***5172** Your committee is aware that many State and local governments operate programs of general assistance which receive no Federal funds and which are designed to meet situations of need not covered by federally financed programs. Similarly, many nongovernmental agencies provide various types of aid to individuals and families on an emergency basis where governmental assistance is not available. These local and private efforts to meet extraordinary and individualized instances of need will form an important complement to the new Federal welfare programs which attempt to meet need in its more predictable and chronic forms. Your committee is, therefore, concerned that cases of mismanagement of the Federal assistance benefits be promptly identified and corrected so that the limited resources of local governments and private charitable agencies will not have to bear the unwarranted burden of duplicating Federal payments which have been misused. To prevent this from happening, local and private agencies which find instances of misuse of benefits should report such findings to the Secretary, who would, on the basis of such reports or any other information he may have indicating misuse of benefits, be required to make an investigation of each such case to determine whether the appointment of a representative payee or other action was appropriate.

In another section of the bill, the Secretary would also be directed to notify appropriate Federal, State, or local officials of information dealing with neglect, abuse, exploitation, or improper care or custody of children.

Your committee's bill would also authorize administering offices to make emergency cash assistance payments in amounts not exceeding $100 where it has been determined that (1) a family requires such emergency cash assistance to meet current needs until the first regular assistance check arrives, and (2) such family is presumably eligible for assistance on the basis of all readily available evidence. Any such emergency payment made to a family would be considered as an advance to be deducted from the first regular check. If the family is found not to be eligible for benefits, the advance would constitute a recoverable overpayment.

To facilitate administration in situations where the family would, because of income, be eligible for a payment of less than $10 per month (less than $30 per quarter), no payment would be made, although family eligibility for manpower and other services would be retained. Also, in order to facilitate payment processes, your committee's bill would permit establishment of ranges of income-- that is, permit use of income brackets-- within which a single benefit amount would apply. This would also permit rounding of payment amounts to the nearest dollar.

(2) Overpayments and underpayments: Your committee's bill would permit adjustments on account of overpayments or underpayments to be made by modifying future benefits of the family or by recovery from any family member. The bill, however, would preclude recovery of overpayments where the family is without fault and recovery would either defeat the purpose of the program or be against equity and good conscience or (because of the small amount involved) impede efficient and effective administration. Narrow bands of about $5 would be employed in establishing adjustment tables so that a minimum of administrative process might be involved, yet maintain equity in the overall adjustment procedures.

***5173** Your committee intends that in determining whether an individual is without fault, the Secretary would consider that individual's age, education, and physical and mental condition. An individual would not be found to be without fault if an incorrect payment which was made to him or on his behalf resulted from his statement which he knew or should have known to be incorrect or from his failure to furnish information which he knew or should have known to be material, or from his acceptance of a payment which he either knew or could have been expected to know was incorrect.

(3) Hearings and review: Your committee's bill requires that there be notice and opportunity for hearings for any individual who disagrees with a determination with respect to eligibility for payments or the amount of the payments. The individual would have to request the hearing within 30 days. Decisions would be rendered within 90 days following a properly submitted request for a hearing. If payments during the hearing process were continued, they would be considered overpayments if the Secretary's initial determination were sustained. Final determinations of the Secretary would be subject

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to judicial review in the Federal district courts. However, determinations as to the facts which the Secretary makes after a hearing provided by him would be conclusive and not subject to judicial review.

Your committee recognizes that many qualified persons who would be capable of hearing issues that arise under the family programs may not meet the specific requirements for appointment as hearings examiners under the Administrative Procedure Act, but might be a good source of examiners to hear issues arising under the family programs. Therefore, under your committee's bill, the Secretary would establish the requirements to be used in selecting examiners. Although the examiners would not be selected under the conditions set forth in the Administrative Procedure Act, full hearings would otherwise be conducted in accordance with the requirements of that Act, which include, for example the rights to submit evidence, to cross examine witnesses, to be heard by an impartial examiner, and to a decision based on the hearing record.

Where an individual who has requested a hearing is represented before the Secretary by an attorney, the provisions of the cash social security programs would be applicable except that there would be no withholding of attorney fees from such individual's benefits. Your committee believes that to withhold such fees would be contrary to the purpose of the programs.

Also, the protective rules and regulations on representation of claimants that apply to the old-age, survivors, and disability insurance program would be applied to the program.

(4) Prohibition of assignments: In order to assure that benefits go to the named payee, these payments would not be subject to assignment or to attachment or garnishment.

(5) Applications and furnishing information: To enable the Secretary to obtain the information needed to determine eligibility or payment amount, your committee's bill would authorize the Secretary to require that individuals file applications, furnish evidence, and report events and changes that might affect eligibility or payment amounts.

(6) Biennial reapplication: Your committee is especially concerned about families that remain on assistance rolls for many years. The new program would assess, better than has been possible before, ***5174** the family situation that requires a family to receive assistance payments for as long as two years. Thus, the bill would require that each such family file a new application, which would be given thorough study in order to verify the continued eligibility of the family and to determine what measures might be taken to prevent that family's continued dependency. In addition, the information developed about this group of families may form the basis for useful studies and analyses of the problems of the long-term poor.

(7) Furnishing of information by other agencies: In determining eligibility and the amount of payments under your committee's bill, the Secretary would verify the information on income and other information given by the claimant. The Social Security Administration has direct access to reports about earnings from employment and self-employment covered by social security. If a recipient has income other than from earnings covered by social security, information from another source would be required in order to verify income reported by the claimant. The Treasury Department would be able to furnish data from income tax returns. Information on certain benefits and payments would be obtained from the Social Security Administration and from other Federal agencies such as the Railroad Retirement Board, and the Veterans' Administration. In order to assure the availability of such information on income and other matters, your committee's bill would require the head of any Federal agency to provide information needed by the Secretary to verify factors affecting eligibility or payment amount.

(d) Methods of determining eligibility for Federal programs.-- As indicated earlier, your committee is absolutely convinced that a key element in welfare reform is the establishment of an effective administrative mechanism. Described here is the way the family benefit provisions would be administered under agreements and understandings between your committee and two Departments concerned:

(1) Use of social security number: The social security number will be used to identify every recipient. Each family member will be so identified and those not having a social security number will be issued one at the time a benefit claim is filed. The social security number of one family member will be used as the primary control number for the family's claim with all other family member numbers cross-referred to this key number on all appropriate records. The proposed record system will be based on these control numbers and all of the data in the claims process will be retrievable and controlled in this manner.

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The bill would also impose a penalty for furnishing false information in order to obtain a social security number. This, together with many other controls and checks in the social security number issuance system, is intended to prevent anyone from obtaining benefits through the use of multiple social security account numbers issued on the basis of false information. This process would eliminate almost completely what your committee believes may be a not uncommon situation today-- a family receiving more than one benefit at the same time.

For example, in order to minimize the possibility that a person could use a social security number obtained on the basis of false information, positive identification in the form of a birth certificate or, when none is available, other acceptable and convincing documents or evidence, for ***5175** all family members would be required upon applications for assistance payments. The Social Security Administration, which is responsible for issuing and maintaining social security numbers and files, would then set up the necessary procedures to assure that an individual is identified with all social security numbers issued to him, so that all earnings of family members would be known. The Social Security Administration would also take whatever action it finds necessary to assure that every person would have a social security number by the time he reaches an age when he may have earnings.

The establishment of these procedures and controls will add to the administrative costs of the Social Security Administration. Your committee recognizes this and also intends that no part of the costs involved be chargeable to the trust funds administered by the Social Security Administration. Such costs are to be provided as part of the regular appropriations for administration of the family programs.

An integral part of the system will be the ability to verify earnings and benefit information received from a recipient, as well as to avoid duplicate payments. Thus, as new cases enter the system, account numbers of all family members will be cross-checked for prior claims history to make certain that no member is receiving assistance payments under another case. At the same time, the information supplied by the family will be used to see if the whereabouts of a deserting parent can be determined from the records of the Social Security Administration. The use of the social security number will also permit the information concerning a family's earnings and other income to be checked against the Social Security Administration's earnings and benefit files, as well as the files of the Railroad Retirement Board, Veterans Administration, Internal Revenue Service, Civil Service Commission, and State employment service. It is expected that subsequent regular periodic checks against these data files will be made.

Your committee is aware that little information exists about the extent of compliance with social security tax reporting provisions in the areas of domestic employment, farm employment, and casual labor. The only study which has been done is almost a decade old, and the results of that study showed extensive non-compliance with the domestic reporting requirements where the earnings per quarter were low but still above the $50-a quarter requirement for tax reporting purposes. Since the social security earnings records will be relied upon to verify the earnings of beneficiaries under these programs, your committee expects the Treasury Department and the Department of Health, Education, and Welfare to take immediate steps to determine the extent of non-compliance with the present social security tax reporting provisions in these employment areas and to take whatever steps are necessary to assure compliance. Increased reporting of taxable earnings for social security purposes will have not only the effect of improving social security earnings records as a check on earnings under the assistance programs, but will also improve the income position of these families as the families become eligible for social security benefits.

(2) Interviews: As part of the application process (which would ordinarily take place after a preliminary determination of whether the family has an employable member), the interviewer will personally advise each individual applying on behalf of the family of the benefits provided under the law, the conditions of eligibility and factors affecting continuing eligibility, benefit rates, terminating events and ***5176** reporting requirements with respect to each eligible family member. He would also advise of the right to a fair hearing and judicial review of determinations, and would remind the applicant of the penalties for making false statements to obtain a benefit. (Application forms will also carry a prominent statement explaining those penalties). Finally, all applicants will be informed that their case may be subject to a full and complete investigation of all aspects of their claims. In those areas where a large number of those who apply cannot speak English it is expected that interviewers speaking other languages would be used, and that forms and information pamphlets would be available in other languages. These practices would follow those now used by the Social Security Administration.

If the interview raises questions regarding the accuracy of statements on the application, a field investigation to verify

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allegations would be conducted prior to authorizing benefits. Such investigations would also be made when a history of non-reported income or non-cooperation of the family shows up in prior case records.

(3) Validation and review control programs: The possibility or probability of a validation check as explained in the interview will be a deterrent to program abuse. Validation will be performed under a continuing eligibility control program. It is expected that such an eligibility control program will consist of complete verification of a scientifically selected sample of applications. The verification would involve checking every element of eligibility in great detail. For example, each birth certificate would be checked against the public record it purports to represent. Earnings would be checked directly with employers, and so on. In addition, the Secretary would validate certain eligibility items on each application as experience demonstrated to be necessary. The verification and review would be performed by specifically trained employees operating out a separate eligibility control unit.

(e) Penalties for fraud.-- Your committee believes that for the new Federal programs the penalties for fraud should be the same as those provided under the social security program since the considerations that lead to provision of such penalties under social security would be equally relevant. Accordingly, the pertinent sections dealing with fraud under the social security program are repeated in the bill and applied to the new programs. Your committee believes strongly that every person attempting by unlawful means to obtain payments not due him under the plan, or otherwise violating any of the penal provisions of the Social Security Act should be prosecuted vigorously as a threat to an effective program. The significance of this requirement goes beyond the potential costs of pursuing the prosecution; prosecutions should not be dropped because the amount of money involved is small or the cost of prosecution high. It is much more important that the public confidence in the integrity of the program be maintained.

(f) Obligations of parents.-- (1) Financial obligation of deserting parent: One of the major causes of increases in the number of AFDC families is parental desertion. To discourage abandonment of families, your committee's bill provides that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States equal to the total amount of assistance benefits paid to the spouse and children during the period of desertion or abandonment. The liability of a deserting parent would be reduced by the amount of any payment he made to his family during the period of ***5177** desertion. In those cases in which a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order.

To the extent these amounts are not collected directly from the individual involved, the amount due the United States under these provisions could be collected from any amounts otherwise due the deserting parent by any officer or agency of the United States or under any Federal program without time limit.

The individual applicant for assistance benefits must of course, cooperate to the fullest possible in establishing eligibility. In this connection an individual applicant will be expected to cooperate in every possible way in assisting the authorities to identify and locate a deserting parent.

Recipients will also be expected to attempt to obtain support payments due from absent parents. The administering agency should insist that recipient families obtain court orders providing for reasonable support payments, but your committee does not expect that agency to go behind the court order in evaluating the adequacy of the payments it directs.

Your committee feels very strongly about these provisions and expresses unequivocally its intent that all Federal and State enforcement machinery should cooperate to the fullest extent possible in implementing these provisions. These activities would be in addition to and coordinated with related activities on the part of the States under provisions in present law. The bill would also create more Federal financial support for those activities.

(2) Penalty for interstate flight to avoid parental responsibilities: Your committee is very much aware of the fact that some families have become AFDC recipients because the father has deserted them, has moved to a different State, and has failed to furnish the financial support which he is legally obligated to give. Although the States have been able to trace missing parents in many cases and frequently to require some financial contribution, your committee believes that specific statutory penalties are required in order to reduce the number of instances where a parent deserts his family and moves to another State to avoid his support obligations.

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Accordingly, the bill provides that a parent who travels across State lines to avoid his parental support responsibility shall be guilty of a misdemeanor. Upon conviction, he would be subject to a fine of up to $1,000 or a sentence of up to one year, or both.

The Department of Health, Education, and Welfare has informed your committee that it has taken steps to increase the effectiveness of activities to locate deserting parents by establishing an office within the Department to coordinate all these activities.

(g) Reports of improper care or custody of children.-- In order to assure that the children in eligible families are protected to the extent possible, the bill directs the Secretary to notify the appropriate Federal, State, or local authorities of any reports he obtains that indicates any child is being or has been subjected to neglect, abuse, exploitation or other improper care or custody.

Your committee is requiring the Secretary to record data on the number and type of such reports that he receives. He is to furnish the Congress with a summary in his annual report evaluating the results achieved, including the number of reports and actions taken.

***5178** 5. Administrative arrangements and agreements

(a) Departmental responsibilities.-- Applicants for assistance under the Opportunities for Families program would be subject to the same basic eligibility requirements and would receive the same payments as those applying under the Family Assistance Plan. Since the Opportunities for Families program would be administered by the Department of Labor, while the Family Assistance Plan would be administered by the Department of Health, Education, and Welfare your committee recognizes the possibility that inequities might arise due to differing interpretations of law or determinations of fact. The bill, therefore, requires that both Secretaries would apply the same rules to arrive at uniform determinations of eligibility and assistance amounts under the two programs. In order to help accomplish this objective, the bill provides that the Secretary of Health, Education and Welfare would prescribe the necessary regulations, with the concurrence of the Secretary of Labor.

The provisions now in Title I of the Act with respect to confidentiality of records would apply to the information which the Secretaries would have in their possession as a result of administering this program.

Your committee expects that contractual arrangements, authorized by the bill between the Department of Labor and Health, Education and Welfare would provide integrated administration of these two programs nationally. Field installations would perform the income maintenance functions with respect to all families in the Opportunities for Families program and in the Family Assistance Plan.

(b) Administrative system for providing child care.-- Your committee's bill requires the Secretary of Labor and the Secretary of Health, Education, and Welfare, both directly (by contract or grant to public or private agencies) and through a system of prime grantees, to provide child care services to those who need them in order to participate in employment, training, or rehabilitation programs. The Secretaries would arrange for the provision of child care services to recipients for as long as they deem it necessary. However, your committee expects that reasonable limitations on the duration of services would be established. The Secretary of Labor is to utilize the first order of priority child care services which have been developed by the Department of Health, Education, and Welfare before going elsewhere for such services. The Department of Labor is required to report regularly on any purchases or program development which it makes outside of the HEW delivery system. This is believed desirable because HEW has the responsibility to take the lead role in the creation of appropriate child care facilities for participants in the Opportunities for Families program, and coordination of such services.

The prime grantee for a geographical area is to be designated by the appropriate elected or appointed official or officials in that area, and would be required to demonstrate a capacity to work effectively with the manpower agency. Where appropriate, consideration should be given to the use of local school systems through arrangements with local educational agencies. Child care programs provided under the act would be of various kinds in order to meet the needs of different children. Both Secretaries are authorized to charge a fee for part or all of the cost of child care in accordance with the family's ability to pay.

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***5179** Your committee believes that these child care provisions would help overcome some of the obstacles which have previously inhibited the development and provision of adequate child care services. By providing for Federal initiative and responsibility and full Federal funding, your committee is making it possible for the Department of Labor and the Department of Health, Education, and Welfare to move expeditiously and quickly, without being required to wait for State or local organizations and agencies to provide matching programs and funding. Where, in the judgment of the Secretary, such matching funds are readily obtainable, however, he is directed to arrange for these to be included in the plans for a specific child care project.

Your committee also expects that each Department will use its grant and contract authority to make certain that the organizations and agencies involved will provide for a greater diversity in the kinds of child care than that which is currently available. For example, school age children could, in many cases be most appropriately cared for in the school when care is needed in out-of-school hours. Each Secretary would be able to utilize public agencies, as well as private, non-profit and profitmaking agencies and organizations. Thus, both the public and private sectors would be used in the provision of child care. The same authority would be available to prime grantees in entering into agreements within their areas of responsibility.

Your committee believes that well-designed child care programs, in addition to benefitting parents by freeing them for work, can also be of great benefit to the child and can help to break the cycle of poverty. Child care for the pre-school child should not be care of low quality, but should include educational, health, nutritional, and other needed services whenever possible. However, the lack of child care of that level would not be good cause for failure to take training, if other adequate and acceptable care is available.

The bill authorizes funds for grants to any public or non-profit private agency, and contracts with any public or private agency or organization, for evaluation, research, training of personnel, technical assistance, or research or demonstration projects to determine more effective methods of providing child care services.

In order to assure that child care resources will be developed as rapidly as possible, the bill provides that the child care provisions will be effective as soon as the bill is enacted into law. In order to give adequate notice of available funding, appropriations for one year, to pay the cost of the program during the next year, would be authorized. Also, to make the transition to advance funding, initial funding under your committee's bill would be provided for the year of enactment of this bill and for the next year.

In order to assure an appropriate division of responsibilities in the furnishing of child care by the two Departments, the following understanding has been reached with your committee:

The Department of Health, Education, and Welfare has primary responsibility for--

(1) Child care planning, technical assistance, staff training, facilities construction and renovation and the creation of new child care facilities through provision for initial operating grants (for up to 24 months, or longer if the Secretary finds it necessary).

(2) Setting child care standards (with concurrence of the Department of Labor) and maintaining quality control.

***5180** (3) Coordinating activities with other child care and social services programs.

(4) Providing child care for vocational rehabilitation participants. The Department of Labor has primary responsibility for--

(1) Arrangement for and purchase of child care services from all available sources for participants in the Opportunities for Families program.

(2) According priority to the purchase of child care services in facilities developed by the Department of Health, Education, and Welfare, before going elsewhere in the market, when use of these facilities is feasible and appropriate.

(3) Providing close and direct link between the manpower agency and child care services.

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(4) Training of mothers for jobs in child care facilities.

(5) Securing child care in private homes as feasible.

The Secretary of Health, Education, and Welfare is authorized to make grants to public or nonprofit private agencies for the cost of alteration, remodeling, or renovation of child care facilities, or where this is not feasible, the construction of new facilities. A sum of not more than $50 million per year is authorized for construction, renovation, and remodeling of child care facilities.

The AFDC program would expire when the new Federal family programs become effective, July 1, 1972. Between the enactment date of this bill and July 1, 1972, the Secretary of Health, Education, and Welfare is expected to use his authority and available child care funds to provide child care services for AFDC families in order to maximize the effectiveness of the present WIN program.

(c) Family planning.-- The Secretaries of Labor and HEW would be required to offer and pay for family planning services to families receiving benefits under the programs. Your committee included provisions in the 1967 public welfare amendments which required the States to offer family planning services to appropriate AFDC recipients. The bill would transfer this function to the Federal government. It is estimated that about 1 2/3 million women could receive family planning services under this provision. Many additional thousands of women in these families would receive family planning services under other programs, including the Maternal and Child Health provisions of Title V of the Social Security Act. In addition, States would still receive 75 percent Federal matching for family planning services on an open-end basis, as under present law.

Lack of knowledge of and access to family planning services has been a major factor contributing to unwanted pregnancies and larger, unmanageable families among the poor. The evidence is clear that these services are desired by recipients and that the information and medical assistance which is made available is utilized. Moreover, experience under the present WIN program shows that a substantial number of women drop out of training and employment due to unwanted pregnancies.

Your committee is very much aware that illegitimacy is a primary cause of dependency and accounts for much of the increase in the AFDC rolls in recent years. This provision is intended to help meet this problem.

***5181** (d) Establishment of local committees to evaluate effectiveness of family programs.-- The bill provides that the Secretaries of Labor and Health, Education, and Welfare would jointly establish or designate local advisory committees throughout the United States to evaluate the effectiveness of the work and training program. At least one such committee would be established or designated in each State. Representatives of labor, business, and the general public would be involved, as well as public officials who are not directly involved in administering the family programs. Each committee would choose its own chairman.

Such committees would be expected to submit reports to the Secretaries at regular intervals. Reasonable expenses of committee members in the performance of committee functions would be paid by the Federal Government and appropriations are authorized for this purpose. No other payments of any sort would be made with respect to these committees.

(e) Evaluation and research; reports by the Secretaries.-- In order to provide for the kind of continuous close scrutiny which these new programs will require, your committee's bill provides that under both the Family Assistance Plan and the Opportunities for Families program, the respective Secretaries are authorized to conduct evaluation studies and conduct research and demonstration projects either directly or by contract. To provide flexibility, the Secretaries are authorized to waive normal program requirements in conducting research and demonstration projects. However, your committee does not intend that any project which waives such requirements would involve any substantial number of people. An annual report to the Congress and the President is required from each Secretary with respect to the program for which he is responsible. These reports should be complete, and should accurately and fully report on the status of the programs. Statistical measurements of the effectiveness of the programs in restoring families to employment and self support and keeping them there should be comprehensive and continuously available.

Your committee is directing the Secretary of Labor, and the Secretary of Health, Education, and Welfare in conducting

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evaluation and demonstration projects, to include locations with special problems, such as high case loads or high unemployment. The Secretary of Health, Education, and Welfare is directed to include in his annual report detailed information on how child care money was spend and a description of the results of such expenditures. He is also to include in his annual reports information on the migration patterns of recipients of assistance programs among the States and the territories.

Each Secretary is authorized an appropriation of $10 million for these purposes.

(f) Transitional administrative provision.-- Your committee is convinced that there should be Federal administration of the new programs. However, your committee recognizes the massiveness of such an undertaking and has provided for a period of transition from the present State and local administration of welfare payments. The bill authorizes the Secretaries of Health, Education and Welfare and Labor to contract with States to administer the Federal assistance plans on behalf of the Federal government for such portions of fiscal year 1973 as would be necessary to provide an orderly transition to Federal administration of the programs. States would not, of course, ***5182** assist in the administration with respect to families where the father is working full time.

F. GENERAL PROVISIONS AFFECTING NEW ASSISTANCE PROGRAMS

1. Effective dates

Generally, provisions relating to the new programs would be effective July 1, 1972. The child care provisions would become effective upon enactment of the bill. In order to provide additional time needed for planning payment mechanisms for families where the father is working full time, the provision affecting them would become effective January 1, 1973.

2. Prohibition against participation in food stamp program by people eligible for payments under family and adult assistance programs

Your committee's bill would amend the Food Stamp Act of 1964 by providing that families and adults eligible for benefits under the assistance programs in this bill would be excluded from participation in the food stamp program.

Your committee also notes that the President has expressed his intention to transfer the food stamp program to the Development of Health, Education, and Welfare. Your committee believes there is considerable merit in such a step because the residual segments of this program would be administered by the same Department which administers the cash payments under this bill.

3. Special provisions for Puerto Rico, Guam, and the Virgin Islands

Your committee's bill includes special provisions for Puerto Rico, Guam, and the Virgin Islands under which the amount of family benefits, and all of the amounts used under the family plan (other than the $720 amount of annual earnings to be disregarded and the $30 incentive allowances for training or rehabilitation services) and the new title XX of the Social Security Act (aid to the aged, blind, and disabled), would be adjusted (but not only downward) by the proportions which the per capita income of each is to the per capita income of the lowest per capita income State.

4. Determinations of medicaid eligibility

Your committee's bill would permit the Secretary of Health, Education, and Welfare to enter into an agreement with a State under which the Secretary would determine eligibility for medicaid. The agreement could include determinations for the medically indigent as well as for eligible for payments under the Opportunities for Families program, Family Assistance Plan and Assistance for the Aged, Blind and Disabled. The State would be required to pay 50% of the additional administrative costs incurred by the Federal government in carrying out the agreement.

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This provision would facilitate a State's election to turn over assistance programs to Federal administration and thereby reduce overall administrative costs. If there is Federal administration of payment programs under this bill without Federal administration of medicaid eligibility a State agency would then be required to duplicate much of the eligibility work already being carried on by the Federal agency. As a result, administrative costs would be high and the beneficiary would be inconvenienced by having to make two applications at two different offices.

***5183** Under present law, States are required to cover under medicaid all people eligible for cash assistance payments. If this provision were carried over into the new assistance programs, many thousands of additional people, the great majority of whom would be people made newly eligible for assistance to the aged, blind, and disabled, would be required to be covered under medicaid. In view of the serious financial and other problems of many State medicaid programs, your committee decided not to require the States to cover the newly eligible but rather leave the decision up to each individual State. Your committee's bill would, therefore, provide that despite any other requirements of Title XIX, no State shall be required to provide medicaid coverage to any individual or family member in any month where such person would not have been eligible for such assistance under the State plan in effect on January 1, 1971.

5. American Samoa

Your committee directs the Secretary of Health, Education, and Welfare to study the desirability of providing assistance payments under the provisions of this bill to residents of American Samoa. The report of the study should be submitted to the Congress before July 1, 1972.

G. THE NEW ADMINISTRATIVE TASKS IN ASSISTANCE PROGRAMS

Your committee recognizes that within a very short time greatly increased administrative responsibilities necessary to carry out the new Federal programs established by this bill will be created for the Departments of Health, Education, and Welfare and Labor. Applications from the large numbers of people who will be newly eligible to receive payments under the Opportunities for Families program, the Family Assistance Plan, and Assistance for the Aged, Blind, and Disabled will have to be processed according to new eligibility rules. New procedures and new policies will have to be formulated, new computer programs designed, and new operating policies worked in for maximum efficiency. It is expected that the two Secretaries will make maximum use of existing resources within their Departments for planning and preparatory steps. Nevertheless, to handle this greatly increased workload, substantial staff will have to be hired and trained and substantial office space and computer time will have to be procured.

Under your committee's bill there would be approximately 19.4 million people potentially eligible for assistance under the Opportunities for Families program (to be administered by the Department of Labor) and the Family Assistance Plan (to be administered by the Department of Health, Education, and Welfare). Under the adult assistance categories, to be administered by the Social Security Administration, there will be about 6.2 million people eligible for payment, about 2.8 million of whom will be people who do not now receive public assistance, but whose income is at or below the payment levels provided for under the committee bill. In order to handle new applications under the Federalized adult assistance categories, additional income and asset information will have to be gathered. Eligibility information maintained by the States for those now on the rolls will have to be adapted to meet the needs and requirements of a national program. In addition to the magnitude of the job to be ***5184** done, the difficulty of administration will be compounded by sensitive timing and coordination problems, especially the need for converting people now on State rolls to the national rolls and working out phasing-in agreements with the States.

Your committee expects that other agencies within the Department of HEW, as well as governmental agencies outside the Department, would lend their support, to the extent consistent with the performance of the duties required to carry out their own programs, to assist the new agency in carrying out its responsibilities. For example, while the administration of the assistance programs for families would be completely separate and distinct from the social insurance programs, the committee would expect that the computer equipment and other capabilities of the Social Security Administration would be utilized in the administration of the family programs to the extent it is economical and efficient to do so. No part of the cost of rendering such service, however, would be chargeable to the trust funds administered by the Social Security Administration.

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Your committee recognizes that the Department of Labor is being asked to take on a very large responsibility in the Opportunities for Families program. It believes the bill reported by your committee provides adequate authority and resources to carry out that responsibility. The Secretary of Labor should have whatever assistance is needed to get the job done. It is recognized that the Secretary will have a large job of securing and training staff to administer the program, and he should take whatever steps are necessary to assure a well-qualified staff. To emphasize its concern for proper staffing and effective administration, your committee's bill would authorize an Assistant Secretary specifically for the Opportunities for Families program.

There will also be a large amount of preparatory work which will have to be performed before offices can be opened to serve registrants, and the Department of Labor will need start-up funds in advance of the effective date of the bill. Your committee's bill contains an authorization for start-up expenditures during the year preceding the effective date of the new program.

It is the intent of your committee that a new agency be established in the Department of Health, Education, and Welfare to administer the Family Assistance Plan and to handle assistance payments for the Opportunities for Families program. The new agency would be responsible for establishing and managing local offices and would carry out other necessary functions with the exception of those which it may find appropriate to contract with other agencies to carry out.

The magnitude of the complex tasks to be completed during the limited time remaining before the programs go into operation requires substantial detailed planning. Immediately upon enactment there should be adequate funding available to permit the administering agency to quickly staff, secure, modify and equip hundreds of servicing offices and obtain the specialized equipment essential to implement the program nationally. This agency must also promptly distribute to the State funds for technical assistance and develop agreements to facilitate initial payments under revised standards and to smooth the transition to Federal Administration.

In order to prepare for the very substantially increased workload involved in administering the assistance program for the adult categories, the Social Security Administration's manpower resources will ***5185** have to be immediately expanded. Moreover, they will have to be increased for subsequent years, also, to insure a fully trained additional complement of staff when the program is in full operation.

H. STATE SUPPLEMENTATION AND FISCAL RELIEF

Your committee believes that the basic Federal assistance benefits provided under its bill represent a realistic attempt to establish uniform national minimum standards of assistance in both the adult and family programs. These new Federal benefit levels are higher than the current levels of assistance in many States and, consequently, considerably lessen the wide variations from State to State which now exist and which are frequently criticized as inequitable and as contributing to the continuing shift of population to large urban areas. Your committee recognizes, however, that, because of the variations in living costs from one area to another and for other reasons, a complete uniformity or assistance levels throughout the nation is not presently attainable nor even necessarily desirable. In general, it is anticipated that those States which now provide assistance at a level below that of the new Federal programs of your committee's bill will find the Federal benefits adequate to meet the essential needs of the poor in their areas while those States which currently have higher payment levels would find it desirable to supplement the Federal assistance payments. Your committee's bill accordingly leaves each State, completely free either to provide no supplementation of Federal assistance payments or to supplement those payments to whatever extent it finds appropriate in view of the needs and resources of its citizens. Each State would also retain complete freedom to revise at any time its determination of whether and to what extent it would supplement the Federal payments.

While the States would have complete discretion as to how much supplementation, if any, should be provided, your committee's bill would not permit State supplemental payments to be structured in a manner which would erode the financial inventives to work which have been incorporated in the Federal programs. Accordingly, those portions of income which are not counted for purposes of reducing the Federal benefit payments would also not be counted for purposes of reducing any State supplementation.

Although, as noted above, your committee recognizes that there may be a continuing need for State supplementation of the

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new Federal assistance programs, it would appear generally desirable that such supplementation be provided through the same agencies which would be established to operate the Federal programs. This would avoid unnecessary duplication of administrative costs, would permit the States to take advantage of the improved methods and procedures which the bill would require, and would tend to foster national uniformity in the operation of assistance programs. Your committee's bill accordingly not only permits the States to enter into agreements with the Secretaries of Labor and Health, Education and Welfare which provide for Federal administration of State supplemental payments, but encourages such agreements by not requiring the States to make any contribution toward the administrative costs arising out of these agreements and by guaranteeing the States that agree to Federal Administration against increases in the cost of making supplemental payments.

***5186** Your committee recognizes, however, that it is customary in many States to take into account, on a case-by-case basis, certain special needs of some families and of some aged, blind, or disabled people who are in unusual circumstances leading to financial needs that are not met under the general standards established by the States. In these instances, many State welfare programs provide a payment for the special need on top of the general need standard. For example, an aged, blind, or disabled person may be unable to provide housekeeping services for himself but not be in need of expensive care in a nursing home or extended care facility. In such a case he sometimes needs the services of a housekeeper who comes in on a regular basis to perform this task for pay; or, he may live in a private home where these services are provided for him for a specified amount of payment. In these circumstances the basic assistance standards of the State may not be high enough to meet his needs and the extra expense may be budgeted and met by the State as a 'special need.' Your committee believes, however, that the responsibility of the Federal Government in administering a State program of supplemental payments should be generally be limited to administration of a basic uniform payment which does not vary according to such 'special need' and is the same throughout the State and that any additional 'special need' payments should be generally made directly by the State. Thus, a State could also pay an additional amount on an individual case-by-case basis to recompense the special needs cases. This additional payment would have no effect on either the amounts payable under the Federal program or the federally administered State uniform supplementation program.

If a State elects to enter into an agreement under which the Federal government administers its supplemental payments, it would have to abide by certain conditions. Supplementation would have to be provided to all individuals and families who were eligible under the basic Federal assistance programs except that, at the State's option, it could exclude families with both parents present and able to work (whether or not actually employed) or it could exclude families in which the father is actually employed full-time. In addition, the State supplementation would have to be provided under such terms and conditions as the Secretary finds necessary for effective and efficient administration. In general, it is anticipated that the same rules and regulations would be applied to both Federal and State supplemental payments with the only difference being the level of such payments. However, the Secretary could agree to a variation affecting only the State supplemental if he finds he can do so without materially increasing his costs of administration and if he finds the variation consistent with the objectives of the program and its efficient administration.

Your committee's bill specifically authorizes the States to establish conditions of eligibility for State supplemental payments which have the effect of requiring applicants to reside within the State for some period prior to receiving such payments. The State would be able to incorporate such conditions into its agreement for Federal administration, and the Secretaries would be expected to carry out those conditions.

By entering into agreements for Federal administration of their supplemental payments, States will be losing all administrative control over the operation of those benefits. Your committee ***5187** expects that the tight Federal administration and the substantial improvements in the work and training aspects of the new Federal benefit programs will bring the expansion of the caseloads under control. It must be recognized, however, that States may not fully share this confidence and also that patterns of State-to-State migration could result in an increase in caseloads for a given State even if national caseloads remain stable or decrease. Your committee's bill, therefore, includes a 'hold harmless' provision designed to assure the States; that their welfare expenditures will not be increased over 1971 levels because of the effects of the provisions of this bill (and the administration of those provisions) on State supplemental payments which are administered by the Federal government. Increased costs arising from changes in the State program (other than an increase in benefit levels to compensate recipients for the loss of food stamp eligibility) would, however, be chargeable to the State.

Under this provision, each State could maintain the levels of payment in effect in January 1971, increased at the State's option by--

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(1) an amount which adds to the income of recipients with income below the payment level the same amount it subtracts from recipients with incomes above the payment level. (To qualify for this option, a State which is not now paying 100 percent of its needs standard would choose one new amount for both its payment level and its standard. That point would be chosen so that calendar 1971 expenditures would exactly equal what they would have been had no change been made.)

(2) an amount equivalent to the bonus value of food stamps at that income level as in effect in January 1971 (whether or not the food stamp program was then in effect in the State), and be assured that its costs in making supplemental payments up to that level during any of the five fiscal years the program will be in effect, would not exceed its actual dollar outlays during the calendar year 1971 under the present programs.

Since the purpose of this provision is to assure a State against rising costs in the situation where it has no direct control, the provision would apply only to a fiscal year during all of which the Federal government was administering the supplemental payment except during the first year where the Federal Government contracts with a State to temporarily administer the Federal programs in such State.

To summarize if a State should decide to supplement the Federal benefit to maintain its present payment levels, including an increase to take account of the loss of the value of the food stamp bonus, and decides to have the Federal government administer the supplemental payment, it will be assured (1) that its benefit costs during the five fiscal years 1973 through 1977 will be no higher than its benefit expenditures in calendar years 1971, and (2) that it will have a net saving for each of those years not less than an amount equal to the costs of administering the present program.

I. AUTHORIZATION-APPROPRIATION FOR SOCIAL SERVICES TO POOR PEOPLE

1. Limiting authorization for social services

The expenditures for social services under the public assistance programs, including medicaid, have been rising rapidly in the last few years. The fiscal year 1971 estimated cost for social services, ***5188** administration, and training is $0.5 billion higher than 1970. Over half of this increase would be for social services.

Your committee has accepted in part the Administration's proposal to close the end of the social services appropriation in order to limit Federal payments to a reasonable level. The Federal government would, however, continue to provide 75 percent matching funds to the States for child care and family planning services on an open-ended basis. Your committee has identified these services as those most likely to facilitate efforts to contain the growing welfare caseload.

While social services and staff training costs are now matched on a 75 percent basis, the Federal Government pays 50 percent of the costs of administering the assistance programs. It has been difficult to separate the administrative costs from the social services and training costs.

The 1972 budget projections indicate that the Federal share of social services costs would increase almost twice as rapidly as the Federal share of administrative costs. Your committee agrees, therefore, that the arrangement provided in this bill should enable the Federal Government and the States to plan their social services system and expenditures better than has been possible heretofore. The Federalization of administration of cash benefits, plus the delineation in the bill of social services in which the Federal government will participate, should also help in meeting this objective.

Your committee's bill would authorize $800 million for social service expenditures in fiscal year 1973 (excluding child care, family planning, and foster care and adoption services). This amount was established by taking into account present expenditures for the services that would be covered, the need for equalization funds, and reasonable growth rates from now until the 1973 fiscal year. Amounts for future years would be determined by the Congress on the basis of its evaluation of the needs and priorities for each year. The Secretary is instructed to allot these sums on the basis of (1) the State's share for services in the previous fiscal years; (2) $50 million to help raise the services levels of States below the national average closer to the national average; and (3) the balance to be apportioned to each State according to its proportion of the recipients under the Opportunities for Families Program, the Family Assistance Plan, and the programs of assistance to the aged, blind,

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and disabled.

Your committee believes this equalization process to be necessary because it takes note of the fact that, for 1971, two States are expected to account for 37 percent of the total Federal expenditures for social services.

2. Services for poor families

The specified services for families which would be paid for under the $800 million authorization would be:

(a) services to unmarried women who are pregnant or already have children for the purpose of arranging for prenatal and postnatal care of the mother and child, developing appropriate living arrangements for the child, and assisting the mother to complete school through the secondary level or secure training so that she may become self-sufficient;

(b) protective services for children who are (or are in danger of) being abused, neglected, or exploited;

***5189** (c) Homemaker services when the usual homemaker becomes ill or incapacitated or is otherwise unable to care for the children in the family, and services to educate appropriate family members about household and related financial management and matters pertaining to consumer protection.

(d) nutrition services;

(e) services to assist the needy families with children in dealing with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home management and maintenance;

(f) educational services, including assisting appropriate family members in securing available adult basic education;

(g) emergency services made available in connection with a crisis or urgent need of the family. Fires, floods, accidents, desertions and illnesses can all be disasters to people which may lead to institutionalization and dependency unless immediate response can be brought to bear on the problem;

(h) services to assist appropriate family members to engage in training or secure or retain employment;

(i) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency or private social agencies) and follow-up activities to assure that individuals referred to and eligible for available services from such other agencies received such services; and

(j) services to meet problems of drug addiction and alcoholism.

3. Services for the aged, blind, and disabled

Specific services available to the adult categories, the aged, blind and disabled, would be:

(a) protective services for individuals who are (or are in danger of) being abused, neglected, or exploited, such as institutional services for those aged or physically or mentally disabled who are unable to maintain their own place of residence;

(b) homemaker services, including education in household and related financial management and matters of consumer protection, and services to assist aged, blind, or disabled adults to remain in or return to their own homes or other residential situations and to avoid institutionalization or to assist in making appropriate living arrangements at the lowest cost in light of the care needed;

(c) nutrition services, including the provision, in appropriate cases, of adequate meals, and education in matters of nutrition and the preparation of foods;

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(d) services to assist individuals to deal with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home maintenance and management;

(e) emergency services made available in connection with a crisis or urgent need of an individual;

(f) services to assist individuals to engage in training or securing or retaining employment;

(g) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency, or private social agencies) and follow-up activities to assure that individuals referred to and ***5190** eligible for available services from such other agencies received such services; and

(h) services to meet problems of drug addiction and alcoholism.

4. Adoption and foster care services

Your committee's bill would authorize Federal assistance to States which provide foster care and adoption services which meet standards prescribed by the Secretary. In order to help assure the availability of adequate medical care to foster children, payments for foster care may include payments for medical care which is not otherwise available. Furthermore, your committee's bill defines adoption services broadly to include payments to adoptive parents in order to provide such parents with necessary assistance in meeting the medical or remedial needs of a child who is hard to place because of a physical or mental handicap. Your committee expects that such assistance will be based upon the financial ability of the family to meet the special needs of the hard-to-place child.

To provide adequate financing of these provisions, your committee's bill includes a separate authorization of $150 million for fiscal year 1972, $165 million for fiscal year 1973, $180 million for 1974, $200 million for 1975, and $220 million for 1976 and later years, for foster care and adoption services. Appropriated funds would be allotted to States on the basis of the child population in each State.

J. PUBLIC ASSISTANCE AMENDMENTS AFFECTING EXISTING PROGRAMS

Your committee believes that the new programs which would be established by the bill will set public welfare in this Nation on a new and constructive course. However, in order to meet the most urgent and immediate needs of the present program until the new programs are in place, your committee has included several changes in the AFDC program which States could put into effect immediately. A description of each of these provisions follows:

1. Optional modification for disregarding earnings under State plans for aid to families with dependent children

Under the present law, the first $30 plus one-third of the remainder plus actual work expenses are deducted from monthly earnings before the benefit amount is reduced. These rules have resulted in an unrealistically high exemption for some AFDC recipients who work. For that reason, your committee is providing in this bill an immediate option that will be made available to the States. They would be able to use the same rules that are contained in the new family programs with respect to earnings disregards and family limitations.

The State could apply the rule of disregarding from earnings the first $60 of monthly earnings and one-third of the remainder, plus the cost of child care (within limits set by regulations). The State could also apply the maximum dollar limits in the family programs on child care, student earnings, and irregular income: $2,000 for a family up to four persons, with a $200 increase in this limit up to a family maximum of $3,000. As indicated earlier in the report, such action would result in substantially lowering the level of earnings at which some benefits are still payable. The provisions would be effective on enactment.

***5191** 2. Increase in reimbursement to States for costs of establishing paternity and locating and securing support from

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parents

Your committee believes that the Federal matching ratio for administrative costs incurred by the States in establishing paternity and locating and securing support from parents should be increased to 75 percent from the present rate of 50 percent. Under the new programs securing support payments will in substantial degree have the effect of first reducing Federal benefits otherwise payable. The States, therefore, would have less financial incentive than now to secure support from parents. The same reduced incentive may be expected to occur in States which would make no supplemental payment to a deserted family, or only a small payment. The proposed change would tend to offset the decrease in incentive by an increase in the Federal share. The change would be effective on enactment.

3. Increase in federal matching for costs of administration and manpower services in the work incentive program

Your committee has become aware that the work incentive program (WIN) has been adversely affected because of the requirement that State welfare agencies assume 20 percent of the costs of providing manpower services and administration. This need for State matching has led to lower program levels in some States, while others indicate either potential reductions or no expansion in existing levels. Since the WIN program will be in effect until June 30, 1972, it seems important to your committee to encourage the States to continue and to expand their present programs. Your committee's bill would therefore immediately increase from 80 percent to 90 percent the Federal share of administrative and manpower costs. This would reduce the amounts of money State welfare agencies will be required to raise. Under the provisions discussed earlier, the Federal government would assume 100 percent of the cost on July 1, 1972.

4. Statewideness not required for social services

The present requirement that social services must be in effect in all political subdivisions of a State or furnished by all subdivisions if locally administered (to obtain Federal matching funds) can have the effect of substantially delaying the implementation of important programs. Your committee believes this requirement should be modified. The bill provides that the Secretary would be able to waive the statewideness requirement with respect to services. The provision would be effective on enactment.

5. Additional remedies for State non-compliance

The administration has asked your committee for legislation providing additional methods for obtaining State compliance under the grant programs of the Social Security Act. The Secretary may now withhold or terminate Federal matching funds when he has determined that a State is not complying with Federal law or regulation. Your committee's bill would provide that he may prescribe other methods to correct administrative non-complaince, including establishing a timetable for corrections and a requirement that persons incorrectly denied benefits by the State be paid retroactively. Federal matching would continue as long as the Secretary is assured that the timetable is being followed. In addition, the Secretary would be authorized, as a ***5192** means of securing compliance, to request the Attorney General to being suit against the State. The provision would be effective on enactment.

6. Individual programs for family services not required

Your committee has been told by the Department of Health, Education, and Welfare that the existing requirement in law to have a social service program developed for each child and relative receiving aid to dependent children has been found in practice to be ineffective, unnecessary and cumbersome. Therefore, your committee's bill would eliminate the requirement. Your committee's bill would require, however, that all needed services will be planned and provided for individuals who need them in order to undertake employment or training until the new programs are in effect. The provisions would be effective on enactment.

7. Separation of social services and cash assistance payments

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Your committee's bill provides that each State would be required to submit by January 1, 1972, a plan which would provide for separating social service administration from cash benefits administration by June 30, 1972. The Secretary could authorize exceptions within a State where he finds it administratively not feasible to separate these functions, as, for example, in the case of very small offices.

The purpose of the provision is to assure that State welfare agencies would be in a position to assist in the administration of the new programs, as agents of the Federal Government, by having a benefit paying organization separate from a social services organization by July 1, 1972.

8. Vendor payments for non-recurring items of special need under AFCD program

States would be permitted to provide non-recurring items of special need by means of vendor payments when the aggregate cost of such items covered by a specific payment is $50.00 or more. The use of the vendor payment method will facilitate meeting non-recurring special needs such as the purchase of furniture and payment for other items essential to living. This provision would enable States to make vendor payments for reasons other than the inability to manage funds as is required under the protective or vendor payment provision of the Act when such payments would result in improved administration, It would avoid situations which have arisen under present law where substantial funds furnished to meet special needs were spent for some other purpose. This provision would permit the States to avoid such situations in the administration of existing welfare programs.

9. Protective and vendor payments under present AFDC program

In the 1967 **social security amendments**, Congress provided for a mechanism under which the States could make vendor and protective payments in cases where a family was found incapable of managing its own funds. In issuing regulations under this provision, the Department of Health, Education, and Welfare misinterpreted the clear meaning of the statute and the explanation of the statutory provision in the committee reports. HEW regulations permit use of this provision only if the entire payment to the family is paid as a vendor or protective payment; States are not permitted to pay part of the benefit to the family and part as a vendor payment or a protective payment ***5193** to a third party, although the statutory language and underlying Congressional intent expressed in the committee reports clearly permit such payments. Your Committee has secured the agreement of the Department to amend its regulations immediately to carry out the original intent of this statutory provision.

K. FINANCIAL AND OTHER DATA ON NEW ASSISTANCE PROGRAMS

Assistance and related payments for adults and for families under the provisions in your committee's bill are estimated by the Department of Health, Education, and Welfare to cost $14.9 billion in fiscal year 1973 as shown in Table 1. This is $5.5 billion more than current law programs would cost. Of the new costs of your committee's bill:

-- $1.6 billion or 29% represents fiscal relief for State and local governments. (Thus, the true increased cost to the taxpayer is actually $3.9 billion.)

-- $1.5 billion or 27% represents additional income for aged, blind and disabled persons.

-- $1.7 billion or 31% represents an investment in assisting low income families to become economically independent. This additional money will purchase increased amounts of day care, training, public service jobs, family planning services and supportive services for families receiving cash assistance.

-- $.7 billion or 13% represents additional income for low income families (not including the impact of public service jobs).

Five year projections of benefit costs are shown in table 2. The increase in cost from fiscal year 1973 to fiscal year 1974 is attributable to increases in the levels of benefits for persons in the adult categories and to the fact that fiscal year 1974 would include a full year of payments to families in which the father is in the home and working full time. The increase from fiscal

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year 1974 to fiscal year 1975 is due to an increase in benefits for the aged, blind, and disabled.

1. Fiscal relief to the States

Table 3 shows the Federal and non-Federal costs of maintenance payments by program and State as they are projected for the fiscal year 1973 under current law. Table 4 presents these costs as they would likely be for fiscal year 1973 under the provisions of your committee's bill. Table 5 presents the difference between these costs; it, represents the fiscal relief that the States will obtain (and, indirectly the cost to the Federal Government of providing that fiscal relief). Table 6 shows estimated savings for State and local governments under H.R. 1, including Federal payments under the provision which assures that a State will not have to exceed its calendar 1971 benefit payments, and savings due to Federal assumption of administrative costs. In all cases, the estimates assume that the States will maintain benefit levels at January 1971 levels, plus the value of food stamp bonuses and will adopt for Federal administration of their supplemental programs, if any.

***5194** TABLE 1.-Potential fiscal year 1973 costs of Assistance provisions under H.R. 1 as reported by the House Committee on Ways and Means

(In billions of dollars)

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***5195** TABLE 2.-Projected potential maintenance payments under H.R. 1 and under current law, fiscal years 1973-77

(In billions of dollars)

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***5196** TABLE 3.-Estimated fiscal year 1973 Federal and non-Federal costs of maintenance payments by State and program (existing law)

(In millions)

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TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

***5198** TABLE 4.-Fiscal year 1973 Federal and non-Federal costs of maintenance payments by State and program under H.R. 1

(In millions)

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TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

***5200** TABLE 5.-Net change in estimated 1973 Federal and non-Federal costs of maintenance payments resulting from provisions of H.R. 1, by State and program

(In millions)

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***5202** TABLE 6.-Estimated savings in welfare expenditures for State and local governments under H.R. 1, fiscal year 1973

(In millions of dollars)

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***5203** Aid to Families with Dependent Children (AFDC) is the present welfare program with the most serious problems and the one in which by far the greatest growth has taken place. Your committee believes that many of the provisions contained in its bill will reduce the number of families which are eligible for assistance and slow down the rate of growth of those which are receiving assistance. The primary difference between the present AFDC program and the new Opportunities for Families program and Family Assistance Plan which are pertinent in comparing the costs of the present program and the proposed program are:

(1) replacing a monthly with a quarterly accounting period with carryovers from 3 prior quarters;

(2) replacing splintered administration with an efficient national system;

(3) downward modifications in earnings disregards;

(4) replacing minimal efforts at training and job creation with a much larger and more effective program.

Thus, it can be expected that State fiscal relief-- the difference between the costs to the States of what welfare would cost under current law and what it will cost under your committee's bill-- will be larger as each year passes.

2. Increased income for aged, blind, and disabled persons

Your committee's bill provides that benefits would be paid under the new Federal program to people who are aged, blind or disabled. In fiscal year 1973, the first year of the program, these benefits would be $130 and $195 a month, respectively, for single persons and couples with no income. In the second year benefits would rise to $140 and $200 and in the third year to $150 and $200.

Based on estimates furnished by the Department of Health, Education, and Welfare, total payments under this new program would be $4.1 billion in fiscal year 1973, $4.6 billion in fiscal year 1974, and $5.4 billion in fiscal year 1975. From then on, costs are unlikely to change significantly since increases in outside income (social security, private pensions, etc.) are likely to offset population growth. The Department estimates that the number of persons eligible for assistance under this new program will be 6.2 million in fiscal year 1973 6.6 million in fiscal year 1974, and 7.1 million in fiscal year 1975.

The new Federal payments would replace the present Federal share of State payments under current law. They would also replace the State share-- in part in some instances and entirely in others. This replacement determines the amount of fiscal relief a State can receive, with respect to adult assistance assuming that benefits to recipients are not reduced. Many current recipients are assured of receiving additional income because the new Federal payment would exceed the old State payments. Many others would also receive additional income even if living in States where the present State payments exceed the new Federal payment. These States would be able to raise payments by the amount of food stamp bonus now available (even for recipients who are not participating in the food stamp program). They would be able to do this either out of their potential savings under the provisions which assure no increase in calendar year 1971 expenditures, they can make the food stamp adjustment at no cost. The estimates furnished by the Department assume that all States do adjust their payments to account for food stamp bonuses. Bases on this assumption, ***5204** it is estimated that current recipients and persons made newly eligible will receive $1.5 billion in additional net income (that is, in addition to present cash benefits and the bonus value of food stamps) because of the provisions in your committee's bill.

3. Investment in training, child care, public service jobs, and supportive services

Your committee's bill improves and provides for increases in programs for training, child care, public service jobs, family

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planning services, and supportive services. The amounts authorized for the first fiscal year of the program are set forth in the bill and are based on what the Administration has promised it will seek in the fiscal year 1973 budget. It is your committee's firm hope and belief that the effectiveness of these programs will justify increases in outlays in the future years. However, no year-to-year increases are shown in the cost estimates because your committee recognizes that the future expenditures in the programs will depend upon the Administration's ability to gear up to full operating levels as well as the effectiveness of each program.

4. Increased income for low income families with children

Your committee's bill provides for a Federal program which would pay direct payments to low income families with children. Federal payments under this program are intended to replace the present Federal share of payments in AFDC. In many instances, they would replace part or all of the current State share as well. Should States, where the present benefit level (including the value of the food stamp bonus) exceeds the new Federal benefit, decide to maintain these levels, they will be able to do so from savings generated directly by the Federal family payments or because of the protection of the provision for assuring States no increase in calendar year 1971 expenditures.

The new program would also make payments to families in which the father is present in the home and working full time. These families are not now eligible for any Federally shared assistance and thus the payments will represent increased income for them. The same is true for families with an unemployed father who live in States that do not maintain an AFDC-UF program. Since the effective date for payment to these families is January 1, 1973, fiscal year 1973 costs represent only six months of payments in this category. The Department estimates that payments in fiscal year 1973 will be $300 million less because of this delay in effective dates.

The Department estimates that a total of 4 million families will receive $700 million in additional income because of the provisions in this bill, assuming that the States elect to maintain benefit levels (including the value of the food stamp bonus). This estimate is for the first fiscal year and does not include the effect of public service jobs on family income.

5. Alternative benefit levels considered

Your committee also considered the basic elements affecting the cost and coverage of plans like those provided for in its bill. These elements are: (1) the amount of benefit provided to a family with no other income (the basic benefit level); (2) the rate at which this benefit level is reduced by earnings (the disregard formula); and ***5205** (3) the level of family income at which it is no longer eligible for any benefit (the breakdown point). Any two of these elements determine the third. They thus also determine the cost of the plan and the number of eligible families.

Raising the basic benefit level is consistent with the desire to provide more adequate support for those households who have no other means of support. Increasing it by $100, however, and keeping other parts of the benefit structure the same, raises the breakeven point by $150, increases the cost by over $500 million per year and the number of eligible families by 300 thousand. The cost of such increases in general gets progressively higher; i.e. each additional $100 in the basic benefit costs more than the preceding one. The reason for this effect is quite simple-- there are more families with earnings in each higher $100 interval. This effect would continue until the level of the breakeven point exceeds average family earnings for the whole Nation.

Raising the proportion of earnings which reduces benefits, sometimes called the marginal tax rate, thereby lowering the breakeven point, is consistent with the desire to reduce costs and prevent households with moderately higher incomes from becoming eligible for benefits. However, it reduces the positive financial incentives for work. Your committee's bill permits the first $60 per month of earned income plus one-third of the remainder to be disregarded in determining a family's benefit.

Your committee believes that the provision allowing one-third of earned income in excess of the first $60 to be disregarded will, in combination with the work requirements, provide the proper mix of incentives and obligations. Increasing the one-third figure to, say one-half, could increase the costs by over $1.0 billion per year.

Table 7 shows the increase in direct Federal cost that would be associated with alternative benefit levels for the family

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programs.

TABLE 7.-Estimated gross Federal payments at different benefit levels, 1972

Family program

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6. Basis of the estimates

Your committee recognizes that projecting the costs of a brand new program poses many problems. It believes, however, that the Department developed its estimates on a sound basis. The following section describes the estimating methodology used. There is first a ***5206** discussion of how the cost of direct Federal payments is estimated and projected over time. After that follows a discussion of how the impact of this new program on State fiscal relief is estimated and then projected over time. Both the procedures and assumptions employed by the Department should be kept in mind when the cost estimates are under consideration.

Earlier estimates of welfare reform costs used as the basic data source the special Survey of Economic Opportunity (SEO). The Current Population Survey developed by the Bureau of the Census for 1969 is now being used as the primary source for the development of cost estimates.

The value of using Bureau of Census survey data lies in the fact that each household in the sample, and the characteristics of the household, bear a distinct and definable relationship to the general population. Therefore, by knowing what effect any given income maintenance program would have on the sample, it is possible to determine the impact of the plan on the total population. Since the survey contains a wealth of information about each household, it is also possible to develop considerable information about the characteristics of the eligible population.

7. Methodology

(a) Family programs.-- In the computation of the cost to the Federal Government and the benefit to families each household in the sample is first identified to determine whether it is a family containing at least one child. Financial records for families with children are taken up one by one, and all computations on each family completed prior to moving to the next family. Results of each computation are recorded and the entries for one family added to those obtained from computations on the records of prior families. At the end of the process, the totals reflect the results of computations for all families.

The procedure for each unit is to: (1) determine whether the interview or family unit contains a child under 18 or a student under 22 and is categorically eligible for a benefit payment; (2) determine the size of the unit so that the benefit payment to the family if it had no income can be computed; (3) count that part of the family income which, under the proposed legislation, would reduce the basic benefit on a dollar for dollar basis; and (4) finally, deduct the countable income from the basic benefit to determine the actual benefit payment. Where countable income exceeds the basic benefit, the benefit is determined to be zero.

The actual benefit paid is the difference between the ‘basic benefit ‘ (payment to a family with no other income) and a family’s ‘countable income. ‘ 4 The total benefits computed in this way constitute the total, direct benefit costs of H.R. 1 as it pertains to families with children.

The latest available survey data is the Current Population Survey which reports on family and household status at the time of the interview (March 1969) and on family income for 1968. These data were projected forward to 1972 and 1976 by incorporating known growth rates in population and income (see Table 8). Since unemployment has increased since the time of the 1969 CPS, it is necessary to increase the estimate by $200 million (based on a study by the Bureau of Labor Statistics). Another $200 million must be added to account for payments in Puerto Rico, which is not included in the CPS.

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***5207** TABLE 8.-Growth factors used in projecting CPS data for family program cost estimates

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Because of the importance of the welfare reform proposals and the uncertainties involved in estimating costs of any new program, a cautious and conservative approach has been adopted. An example of this conservative approach is reflected in an adjustment made in the CPS to correct an apparent inconsistency between the survey data and actual program data. The amount of public assistance income reported in the survey is less than the actual dollars paid out as public assistance. Most professionals in the field believe that this is the result of interviewed families failing to report receipt of welfare income. Nonetheless, an adjustment was made in the data under the very unlikely possibility that the entire discrepancy is explained by a failure to include the appropriate number of public assistance recipients in the survey. This adjustment technique increases the estimated cost of the programs.

The estimated cost of your committee's proposals includes over $2.2 billion in the first full year for training, day care and other supportive services. The only 'savings' in assistance payments costs resulting from this investment that has been explicitly included in the estimates is the $300 million savings from public service jobs. Obviously there are greater potential savings than this.

(b) Adult programs.-- The two largest groups eligible for assistance under Title XX of your committee's bill are the aged and the disabled. The Department of Health, Education, and Welfare estimates that there will be 6.2 million aged, blind, and disabled people eligible for the new Federal assistance program in fiscal year 1973. Estimates of the number of disabled and the amount of benefits for which they would be eligible have been based on the Survey of the Disabled conducted by the Department in 1966. Estimates of the number of aged eligibles and their amount of benefit are produced through similar procedures as those used for the family program.

First, the aged population living outside institutions was assumed to change between 1968 and 1972 in accordance with the pattern shown by Census Bureau projections. The number of married couple units was projected from 1968 to 1972 on the basis of the most recent Census projections of households and families. (The Social Security ***5208** Administration Actuary's estimate of population growth between July 1969 and July 1973 is about the same as that shown by the Census Bureau).

Within the population groups, it was assumed that the proportion of aged unites with various types of nontransfer income-- that is, wages and salaries, self-employment income, and property income-- did not change between 1968 and 1972. For example, 43 percent of males aged 65 to 69 in 1968 had wages in 1968 and so it was assumed that 43 percent of those aged 65 to 69 in 1972 had wages in 1972. Similarly, 22 percent of males aged 70 to 74 had wages in 1968 and so it was assumed that 22 percent of males aged 70 to 74 in 1972 had wages. The general result was that one in four aged units received wages in both 1968 and 1972.

The wage and salary disbursements component of personal income is expected to increase by about 40 percent between 1968 and 1972 according to estimates prepared in connection with the 1972 Federal budget. Aggregate wage and salary disbursements to the aged population were assumed to increase at about the same rate as those to the total population. The increase in the total number of aged units receiving wages, from 3.8 million in 1968 to 4.0 million in 1972, accounted for part of the increase. The remainder was attributed to an increase in average wages, which amounted to 29 percent. Each aged unit with wages was assumed to have the same relative increase in wages-- that is, the 1968 wage entry for each aged unit on the data tape was multiplied by 1.29 to simulate 1972 wages. The combined result of a larger number of units receiving larger wages was that aggregate wage payments to the aged rose from $15 billion in 1968 to $21 billion in 1972.

Similar procedures were followed for the other types of nontransfer income with the following results.

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Public transfer income (other than public assistance) on the CPS data tape is entered in two components-- the sum of unemployment compensation, workmen's compensation, government employee pensions, veterans' payments, and the sum of social security and railroad retirement. The first component-- the item containing government employee pensions and so on-- was estimated for 1972 in a manner similar to wages and salaries. The proportion receiving transfer payments was assumed to remain unchanged between 1968 and 1972 within sex and age group and the aggregate was increased on the basis of information contained in the 1972 budget document. The resulting factor applied to the transfer income of each aged unit with such income was 1.39.

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***5209** The second component-- social security and railroad retirement-- was derived as follows. The proportion of aged units receiving social security and/or railroad retirement benefits in 1968 was about 83 percent according to the CPS data tape-- about the same as the SSA Actuary's estimate of the proportion receiving social security benefits at that time. By the end of 1972 the SSA estimates that about 87 percent of all aged persons will be social security beneficiaries-- an increase of about 1.8 million persons between 1968 and 1972. The CPS data were adjusted within each sex/age of head group to reflect the increased proportion estimated by the SSA Actuary. This was accomplished by increasing the weight of each unit on the data tape who reported receiving social security and/or railroad retirement benefits by the ratio of the number of beneficiaries in 1972 to the number in 1968 as estimated by the SSA Actuary. The weight of each nonbeneficiary was appropriately decreased. The result was an estimated 17.1 million aged persons receiving social security and/or railroad retirement benefits-- an increase of 1.8 million over the 1968 figure.

The SSA Actuary estimates that the average benefit will increase about 45 percent between 1968 and 1972, reflecting three legislative increases of 15 percent, 10 percent, and 5 percent plus benefit increases due to the fact that new beneficiaries coming on the rolls have higher past earnings, on the average, than those going off the rolls. Finally, a special adjustment is introduced to account for the changes in widows' benefits provided by your Committee's bill.

(c) Estimating State fiscal relief.-- The data contained in the Current Population Survey are extremely useful for making aggregate, national estimates of the costs of cash assistance programs. However, because of the nature of the sampling procedures, the survey cannot be used as the basis for making individual State estimates. Nor can it be used to estimate the impact of the new, Federal program on State fiscal relief. A separate procedure was employed to accomplish this.

The states furnish the Department of Health, Education, and Welfare with estimates of the number of recipients and the amount of benefit payments they have projected for fiscal year 1972. By estimating what the Federal payments to these recipients would be under the new program, and subtracting that amount from the States' estimates of total payments under current law, the amount of States would have to pay to keep recipients at the same income can be determined. The estimate of the Federal payments is based on survey data for each of the individual States. Large sample, detailed surveys were taken in the Aid to Families with Dependent Children program in 1967 and in the Old Age Assistance program in 1965. (Smaller surveys have been taken more recently. They cannot be used on a State-by-State basis but are used to update the earlier surveys.) These surveys include data of family size and income by type of income which are the factors that determine what the Federal benefit to each household will be. It was assumed that the characteristics of the caseload would have remained the same since the survey, except for income which was increased in the same manner that was employed in adjusting the CPS data discussed above.

Since it was assumed that the States would make up the value of the food stamp bonus in their supplemental programs, a separate ***5210** computation for this was necessary. The average food stamp bonus for participating public assistance recipients was estimated based on November 1970 actual program data. This average was applied to the entire estimated 1972 caseload to determine the amounts necessary to provide the value of the food stamp bonus to all recipients-- both those who had been participating and those who had not.

The States' estimates of 1972 costs and caseloads and the Department's estimates of what Federal and supplemental payments would be if your committee's bill were in effect for 1972 formed the benchmark for projecting 1973 and later costs.

The following annual growth rates were used in the projections:

(In percent)

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It was assumed that benefit levels would not change except as specified in your committee's bill. For both current and proposed aged programs, and for the proposed disabled program, it was assumed that income growth would offset population growth. In contrast, it was assumed (based on recent experience) that the disabled program, if left unchanged, would continue to grow. As mentioned earlier, it was assumed that the provisions contained in your committee's bill would substantially reduce the growth rate in family cases.

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Estimates of State savings assume that all State turn administration of any supplemental programs over to the Federal government and incur no administrative costs. These administrative cost savings were estimated by projecting forward current State costs at the rate that wage and salary income is expected to grow. (6.3% per year)

***5211** TABLE 9.-Federal and non-Federal shares of maintenance payments by State under current law and under H.R. 1

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***5212** TABLE 10.-Percentage distribution of Federal expenditures for maintenance payments by State under current law and under H.R. 1

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***5213** TABLE 11.-Projected recipients under current law and persons eligible for benefits under H.R. 1, fiscal year 1973-1977

(In millions)

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TABLE 12.-Number of welfare recipients under current law and number of persons eligible for benefits under H.R. 1 by State, fiscal year 1973

(In thousands)

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***5214** TABLE 12.-Number of welfare recipients under current law and number of persons eligible for benefits under H.R. 1 by State, fiscal year 1973 Continued

(In thousands)

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***5215** TABLE 13.-Summary of characteristics of families eligible for family payments in January 1973

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***5216** TABLE 14.-Estimated number of families eligible for family payments benefits in January 1973, by occupations of family heads

(Numbers in thousands)

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***5217** TABLE 15.-Estimated number of families eligible for family payments in January 1973, by work experience and sex of head

(Numbers in thousands)

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***5218** TABLE 16.-Estimated number of families eligible for family payments in January 1973, by number of earners in family and sex of family head

(Numbers in thousands)

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TABLE 17.-Estimated number of families eligible for family payments in January 1973, by residence in SMSA and sex of family head

(Numbers in thousands)

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***5219** TABLE 18.-Estimated number of families eligible for family payments in January 1973, by size of family

(Numbers in thousands)

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TABLE 19.-Estimated number of families eligible for family payments in January 1973, by region of residence and sex of head

(Numbers in thousands)

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***5220** TABLE 20.-Estimated number of families eligible for family payments in January 1973, by race of head and sex of head

(Numbers in thousands)

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TABLE 21.-Estimated number of families eligible for family payments in January 1973, by education of family head

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TABLE 22.-Estimated number of families eligible for family payments in January 1973, by number of children in the family and sex of family head

(Numbers in thousands)

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***5221** TABLE 23.-Estimated number of families eligible for family payments in January 1973, by region of residence, race of head and sex of head

(Numbers in thousands)

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***5222** L. TAX AMENDMENTS

1. LIBERALIZATION OF CHILD CARE DEDUCTION

General statement

Under present law, certain categories of taxpayers are granted limited income tax deductions for amounts they spend for the care of a dependent child where this enables the taxpayers to be gainfully employed. In general terms, this deduction for child care expenses has been fully available where there was only one employable parent in the family or where the combined earnings of the husband and wife were not greater than the median family income level in the United States. The median income level at the time this provision was revised in 1964 was approximately $6,000. More specifically, the categories of taxpayers eligible for child care deductions under present law are:

1. Working wives where the adjusted gross income of the husband and wife does not exceed $6,000 and a joint return is filed (the deduction in this case is phased out on a dollar-for-dollar basis for income above $6,000),

2. Working wives whose husbands are incapable of work because they are physically or mentally incapacitated,

3. Widows and working women (other than wives) with children,

4. Widowers, and

5. Husbands whose wives are incapacitated or institutionalized (if the wife is incapacitated but not institutionalized the $6,000 limit referred to above applies).

Although the deduction is primarily concerned with the expenses for the case of a dependent child (under age 13), it is also available to a taxpayer supporting other dependents unable to care for themselves because they are physically or mentally incompetent.

Under present law, the maximum deduction for child care expenses is $600 in the case of one dependent, and $900 for two or more dependents. At the time this deduction was first made available, the $600 figure represented the exemption level. This level was provided because the Congress had concluded that the additional expenses for the care of a child should be limited to the same amount allowed for a personal exemption.

The committee believes that this child care provision needs updating in two respects. First, the level of the deductible expenses needs to be raised. The exemption level has increased from the $600 level in effect in 1954 when this provision was first adopted to a level of $750 applicable for 1973 and subsequent years. It is also clear that since 1954, the cost of child care has increased sharply. For these reasons, your committee's bill raises the maximum child care deduction for one child from $600 to $750. For the second child, as under prior law, the equivalent of an additional half exemption is allowed raising the total for two dependents from $900 to $1,125. The bill further liberalizes present law by granting an additional increase in the deduction for a taxpayer who has three or more dependents. Such a taxpayer is to be allowed a maximum deduction of $1,500 instead of the $900 provided under present law.

***5223** Second, average family incomes have risen sharply. Since 1964, median family incomes have risen from about $6,000 to nearly $10,000 in 1970. Your committee concluded, therefore, that it was desirable to raise substantially the income level where the child care deduction is available for two working parents. The committee concluded that it was desirable to make provision for those with combined income levels somewhat above the current median family income level. Therefore, it raised this allowable level to $12,000.

These amendments are to be effective for the calendar year 1972 and later years.

The annual revenue cost of these changes is expected to be approximately $75 million. This does not take into account any expansion in the work force stimulated by this credit.

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General explanation

To accomplish the results referred to above, the bill amends present law (sec. 214(b)(1) to provide that the child care deduction is not to exceed $750 where there is one dependent, is not to exceed $1,125 where the taxpayer has two dependents, and is not to exceed $1,500 where the taxpayer has three or more dependents. In all of these cases the deduction actually taken, as under present law, may not exceed the actual child care expenses incurred for the purpose of enabling the taxpayer to be gainfully employed.

The bill also amends present law (sec. 214(b)(2) by increasing from $6,000 to $12,000 the combined adjusted gross income that a husband and wife may have and still be eligible for the child care deduction. For those with incomes immediately above this level, a reduced child care deduction may be taken, the amount decreasing on a dollar-for-dollar basis with respect to each dollar of income of the husband and wife above $12,000. Thus, where there is one dependent, no child care deduction would be available to a couple with a combined income level above $12,750. In cases where there are three or more dependents, no deduction will be available where the combined income level is above $13,500.

The amendments referred to here apply to taxable years beginning after December 31, 1971.

2. TAX CREDIT FOR THE ELDERLY

General Statement

Individuals 65 Years of Age or Over.-- Under present law, individuals who are 65 years of age or over may receive a tax credit based on the first $1,524 of retirement income. The credit is 15 percent of this retirement income. Each spouse who is 65 or over may compute his tax credit on up to $1,524 of his own retirement income (whether they file separate or joint returns). Alternatively, spouses 65 or over who file joint returns may compute their credit on up to $2,286 of retirement income (one and one-half times $1,524) even though one spouse received the entire amount of the retirement income.

To be eligible for this credit, however, an individual must have received more than $600 of earned income in each of 10 years prior to the taxable year (a widow or widower whose spouse had received such earned income is considered to meet this earned income test).

***5224** Retirement income, for purposes of this credit, includes taxable pensions and annuities, interest, rents, dividends, and interest on Government bonds issued especially for the self-employed setting aside amounts under H.R. 10 retirement type plans.

The maximum amount of this retirement income which an individual may claim ($1,524 or $2,286 for certain married couples) must be reduced for two board categories of receipts. First, it must be reduced (on a dollar-for-dollar basis) by the amount of social security, railroad retirement or other exempt pension income received by the taxpayer. Second, the maximum amount of retirement income that can be eligible for the credit is further reduced by one-half of the annual amount of earned income over $1,200 and under $1,700 and by the entire amount of earned income in excess of $1,700. This reduction for earned income does not apply, however, in the case of individuals who have reached the age of 72.

Your committee believes that it is desirable to recast the present retirement income credit for several basic reasons. One reason is that the credit needs updating. Most of the features of the present credit have not been revised since 1962 when the maximum level of income on which the credit is computed was set and when the current earnings limits were established. [1A] Since then, there have been numerous revisions of the social security law which substantially liberalized the social security benefits. As a result, the present maximum amount of income eligible for the credit is considerably below the maximum social security primary benefit over $2,500 available for a retired worker and the maximum social security primary and supplementary benefit of slightly over $3,750 available for a retired worker and his spouse.

In addition, the complexity of the present retirement income credit prevents it from providing the full measure of relief it was

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intended to grant to elderly people. This complexity stems from an attempt to pattern the credit after the social security law in an attempt to give persons not receiving social security payments the same tax benefits as social security recipients. For example, to claim the credit on his tax a year for 10 years; he must also segregate his retirement income from his income; he must reduce the maximum amount of retirement income eligible for the credit by the amount of his social security income and by the specified portions of his earned income under the work test; a credit of one and one-half times the basic credit is available for a man and wife; and a credit is available for each spouse separately if each spouse independently meets the eligibility tests.

The purpose of all of these provisions is to provide individuals who receive little or no social security benefits the opportunity to receive tax treatment roughly comparable to that accorded to those who get the maximum amount of tax-exempt social security benefits. However, the result has been to impose severe compliance burdens on large numbers of elderly people, many of whom are not skillful in filing tax returns. Such individuals must now compute their retirement income credit on a separate schedule, which occupies a full page in the tax return packet, with 19 separate items, some of which involve ***5225** computations in three separate columns. It is these complexities which undoubtedly account for the fact that some of the organizations representing retired people have estimated that as many as one-half of all elderly individuals eligible to use the retirement income credit do not claim on their tax returns.

The present retirement income credit is also defective in that it discriminates unfairly between individuals with modes incomes depending on the source of their income. As indicated above, the credit is available only to those with retirement income-- that is, some form of investment or pension income in the taxable year. Elderly individuals who must support themselves entirely by earning modest amounts of income and who have no investment or pension income are not eligible for any relief under the present credit. This has given rise to considerable complaints as to the fairness of the tax law; many of these elderly individuals who rely entirely on modest amounts of earned income maintain that they should be allowed the same retirement income credit as those who live on investment incomes. They point out that under the present credit elderly people who rely entirely on modest amounts of earned income are required to pay substantially higher taxes than individuals who are comparable in every respect except that they have significantly larger incomes which come from investments. Your committee agrees that such a difference in tax treatment cannot be justified.

To deal with the problems described above, your committee first updated the amount on which the credit is based and also revised upward the earnings limitations. Then the committee dealt with the problem of complexity by no longer attempting to pattern the credit closely after the social security provisions. Instead, to the extent practical, complicating features of the credit which previously were included in order to parallel social security treatment have been eliminated. Thus the $600 ten year earnings test has been eliminated, as has the requirement that the taxpayer have ‘retirement income ‘ (that is, pension or investment income) in order to be eligible for the credit. In addition, the variation in treatment of married couples depending on whether they are separately eligible for credits is eliminated. At the same time equity has been improved by making the credit more generally available to those age 65 or over. The major extension of the credit in this respect is that it will, for the first time, benefit low-income earners age 65 or over. Since the credit is no longer limited to retirement income, it has been renamed the ‘credit for the elderly.‘

To update the credit, the maximum amount on which the credit is computed is increased from the $1,524 under present law (or $2,286 for some married couples or $3,048 for other married couples where both are separately eligible for the credit) to $2,500 for single persons or married couples filing joint returns with only one spouse age 65 or over and to $3,750 for married couples filing joint returns where both spouses are age 65 or over. (The maximum amount on which the credit is based is to be $1,875 for a married person filing a separate return). These higher amounts closely approximate the current maximum levels of social security benefit payments.

These maximum amounts for computing the credit are reduced, as under present law, by social security benefits and other exempt pension income.

***5226** In addition, the maximum amounts are reduced by one-half of earnings in excess of $2,000 received by a single taxpayer or by each spouse if married and filing a joint return (or in excess of $1,000 for married couples filing separate returns). This may be compared with the reduction required by present law of one-half of earnings between $1,200 and $1,700 and of all of the earnings in excess of $1,700. This new level at which earnings result in a reduction is the same as that for social security benefits provided by other provisions in the committee bill.

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After these reductions of the maximum amount for social security and earnings the credit is determined by simply multiplying the reduced amount by 15 percent. While no limitation to the amount of retirement income is required, the reduction of the amount on which the credit is computed by earnings in excess of $2,000 insures that the benefit of the credit will be limited to relatively low-income elderly earners.

Based upon 1973 exemption levels (when the tax relief provisions of the Tax Reform Act of 1969 will be fully effective) a single individual age 65 who receives the maximum retirement income credit could receive up to $4,021 before paying any income tax under present law if the income is exclusively from pension or retirement income sources. Under the new credit for the elderly, he may receive up to $4,842 of income and still pay no tax again if the income is exclusively from pension or retirement income sources. In addition, under the new provision, for the first time he may receive up to $4,000 of earned income and still pay no income tax. Moreover, in the case of the individual with income exclusively from earnings, some credit for the elderly is available up to an earnings level of $7,000. [2] Under present law, of course, an individual with income entirely from earnings receives no benefit from the retirement income credit.

Under present law (1973 exemption levels), a married couple filing a joint return where both are age 65 or over may receive $6,331 of pension income before paying any tax. [3] Under the new credit for the elderly, they could receive up to $7,837 of pension or investment income before paying any tax. Under the new credit, even for the couple with earned income, they could earn up to $6,520 without being taxable. [4] Moreover, the new credit continues to be of some value to a married couple with earnings of up to $11,500 if a joint return is filed and both are age 65 or over. [5]

There will be a few rare instances in which a higher tax than under present law may result from the new credit. These cases arise where one spouse has pension or investment income and is eligible for the credit under present law and the other spouse has earned income. Under present law, the earnings of the other spouse do not reduce the base for the retirement income credit as is provided under the new credit. Your committee concluded, however, that the very substantial additional simplification of the tax form brought about for the majority of the elderly which results from eliminating the separate husband ***5227** and wife computation procedure (which requires an additional two columns on the tax form) justifies the combination of the earnings requirement.

Moreover, the effect of the combined earning requirement is lessened by increasing the earnings limitation to $2,000 for each spouse and by phasing out the amount on which the credit is based for earned income above $2,000 on a 50 cents per dollar basis rather than on the dollar for dollar basis provided by present law. Moreover, it seems appropriate, since the credit is to be available for earnings, to take account of all of the earnings of a married couple, not merely the earnings of one spouse.

An example of the type of simplified tax credit form for taxpayers age 65 and over which these changes make possible is shown below. This form is less than one-third as long as the present form and involves only one column instead of three. It requires the taxpayer to select the appropriate amount on which to compute the credit and to deduct from this social security or certain other tax-exempt income. It also requires the taxpayer to deduct earned income above specified levels. On the balance, the credit is computed at a 15 percent rate, and this is then entered on the face of the tax return as a tax credit. [6]

SCHEDULE R.-Credit for taxpayers age 65 and over

(Joint returns with one spouse under age 65 who has public pension income, use Schedule S)

MAXIMUM AMOUNTS FOR CREDIT COMPUTATION

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

***5228** Those under 65 receiving pensions from public retirement systems.-- Under present law, individuals under the age 65 also are eligible for tax credits for retirement income but only with respect to pensions received under a public retirement system. Only income from a pension, annuity, retirement, or similar fund or system established by the United States, a State, or a locality qualified under this provision This restriction of retirement income for purposes of the credit to income from a public retirement system applies only until the individual reaches the age of 65; thereafter he is entitled to take the credit on

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the same basis as other individuals who have reached that age.

The retirement credit for individuals under 65, apart from the fact that it applies only to a pension under a public retirement system, presently is much like the credit applying to individuals 65 and over. (There are some other differences, however, which are noted below). Thus, it is limited to 15 percent of retirement income up to $1,524. Each spouse under 65 may claim the credit on up to $1,524 with respect to his own public retirement income either on joint or separate returns. However, unlike married couples 65 or over, those under 65 who file joint returns are not entitled to a $2,286 ceiling in computing the credit.

To be eligible for the credit, individuals under 65 also are required to meet the same 10 year $600 earnings test as those over 65. Similarly, for those under 65, the maximum amount of public retirement income that can be eligible for the credit is reduced one dollar for each dollar of social security or railroad retirement pensions received. However, the reduction in the maximum amount eligible for the credit because of earnings is different for individuals under age 62 who are receiving public retirement pensions. In the case of such individuals, this maximum amount is reduced dollar for dollar for all earned income over $900. Starting with age 62, however, those receiving public retirement pensions are eligible for the same more liberal earnings rules which apply to persons who are 65 or over; that is, under present law, the maximum amount on which the credit is based is reduced by one-half the amount of earned income over $1,200 but not over $1,700, and the full amount of earned income in excess of $1,700.

In view of the liberalized base for the credit made available to those age 65 or over by this bill, your committee made comparable liberalizations in the amount of public pension income eligible for the retirement income credit. To some extent the application of the earnings test has also been liberalized for those receiving public retirement pensions.

The maximum amount on which the tax credit computation may be made for this group is increased from the present $1,524 to the same amounts provided by the new credit for those age 65 and over. As is the case under present law, however, the credit is limited to the amount of public pension income received. In addition, the earnings level above which earnings reduce the base for the credit is increased from $900 to $1,000 for those under age 62. For those from age 62 to 65, the earnings limitation is increased so that the amount on which the credit is based is reduced for one-half of earnings over $2,000.

The principles and method of computation of the credit are essentially the same as present law. Like the new credit for those 65 and over, however, the revised retirement income credit requires that the ***5229** earnings of both spouses be combined in the case of a joint return; the separate computation of present law is eliminated. [7]

Your committee concluded that the form used for computing the tax credit for those age 65 and over should not be combined with the form used for the public service retirees eligible for credit who are under age 65. Part (although by no means all) of the complexity of the present form stems from different requirements applicable with respect to public service retirees and the general retirees age 65 and over. The different variables which must be accounted for on the return form are increased substantially when the two somewhat different types of credits are combined on a single form. An example of a tax credit form which might be used for public retirees under age 65 is shown at the end of the general explanation below.

Revenue effect.-- It is estimated that the changes made for those over age 65 and also for the public service retirees under age 65 will result in an annual revenue loss of $375 million.

Effective date.-- The changes described above are to be effective for the calendar year 1972 and later years.

General explanation

Individuals 65 years of age and over.-- In general, the credit for the elderly provided by the bill (sec. 37 of the code) liberalizes the retirement income credit available under present law for those age 65 and over in four respects. First, the amount of income with respect to which the 15-percent credit may be claimed is increased to $2,500 for a single person and to $3,750 in the case of a married couple filing a joint return. Second, all types of income, including earned income, are to be eligible for the credit. Third, for individuals between ages 65 and 72, earned income received by them is to reduce the maximum amount eligible for the credit only to the extent of one-half the amount of this income in excess of $2,000. Fourth, the credit is to be available regardless of whether the individual has had work experience (i.e., has received earned income) in

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prior years. (In addition, as discussed more fully below, the bill also liberalizes the credit presently allowed persons under 65 years of age who are receiving pensions or annuities from a public retirement system.)

Under the bill the amount with respect to which the 15-percent credit may be claimed (referred to in the bill as the 'section 37 amount') may not exceed a maximum amount (referred to in the bill as the 'initial amount') of $2,500 in the case of a single individual age 65 or over or a married couple filing a joint return where only one spouse is age 65 or over. In the case of a married couple filing a joint return where both spouses are age 65 or over, the maximum amount is $3,750. (As under present law the age of an individual is to be determined as of the close of the taxable year in question). This credit is to be available whether or not the individual (or his spouse in the case of a joint return) has received $600 of earned income in ten prior years.

The maximum amount is to be reduced by amounts received by the individual (and by his spouse in the case of a married couple filing ***5230** a joint return) as a pension or annuity under the Social Security Act, the Railroad Retirement Acts or as a pension or annuity which is otherwise excluded from gross income.

In addition, there is to be a further reduction of the maximum amount for certain amounts of earned income received by the individual (and by his spouse in the case of a married couple filing a joint return). (As under present law, no reduction is to be made for earned income of an individual age 72 or over.) In the case of a single individual, the maximum amount is to be reduced by one-half of the amount of earned income received by the individual for the year in excess of $2,000.

In the case of a married couple filing a joint return, this earned income reduction is to be determined separately with respect to the earned income of each spouse. In other words, each spouse is to separately compute the amount of this reduction (i.e., one-half the amount of earned income received by him (or her) in the taxable year in excess of $2,000) and then these separate amounts are to be aggregated to determine the total amount of the couple's earned income reduction. Where only one spouse (of a married couple filing a joint return) is age 65 or over, earned income of the spouse under age 65 is to reduce the couple's maximum amount to the extent of one-half of the excess of that income over $2,000, regardless of the age of that spouse (unless that spouse is the recipient of a public retirement system pension in wich case the earned income reduction rules discussed below are to apply).

In the case of a married individual age 65 or over filing a separate return, the maximum amount with respect to which the credit may be claimed is $1,875. In addition, the amount of the reduction for earned income received by the individual is to be one-half the amount of the individual's earned income in excess of $1,000, rather than $2,000.

Those under 65 receiving pensions from public retirement systems.-- In the case of individuals under age 65, the bill continues the allowance of a credit to those who receive a penson or annuity from a public (Federal, State or local) retirement system. This treatment is to be available, however, only if the pension or annuity received by the individual is paid in respect of services performed by him (or if he is deceased, by his spouse). In the case of a single individual, or a married couple filing a joint return where only one spouse is receiving a public retirement system pension, the maximum amount which may be taken into account for purposes of the credit is $2,500. In the case of a married couple filing a joint return where both husband and wife receive public retirement system pensions the maximum amount is $3,750.

As in the case of those 65 years of age and over, the maximum amount is to be reduced by pensions or annuities received by the individual (and by his spouse in the case of a married couple filing a joint return) under the Social Security Act, Railroad Retirement Acts, or which are otherwise excluded from gross income.

In addition, a reduction in the maximum amount is to be made for certain amounts of earned income received by the individual (and by his spouse in the case of a married couple filing a joint return). If the individual is between the ages of 62 and 65, the amount of the reduction is to be one-half the amount of earned income received by him for the year in excess of $2,000. If the individual has not attained the ***5231** age of 62, then the amount of the reduction is to be the amount of his earned income for the year in excess of $1,000. In the case of a married couple filing a joint return (whether one or both are receiving public retirement system pensions), the earned income reduction is to be applied separately with respect to each spouse (both with respect to the earned income received in the taxable year by each spouse and with respect to the age of each spouse), and then the amounts of the separately computed reductions are to be aggregated to determine the couple's total earned income reduction.

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The bill provides an additional limitation on the amount which may be taken into account for purposes of the credit in the case of individuals under age 65. Namely, the amount taken into account may not exceed the amount of public retirement system pension income received by the individual for the year. In the case of a married couple filing a joint return where both spouses are receiving public retirement system pension income, no more than $2,500 of this type of pension income may be taken into account with respect to each spouse for purposes of this additional limitation (although the total base of the credit for such couple is limited, of course, to $3,750).

For example, assume a married couple under age 65 filed a joint return and did not receive any social security (or similar amounts) or earned income which caused a reduction in their $3,750 maximum initial amount. If one spouse received $3,000 public retirement system pension while the other spouse received only a $100 public retirement system pension, the additional limitation would be $2,600 (that is, $2,500 of pension income of the one spouse and $100 of pension income of the other spouse). Accordingly, the amount with respect to which the credit could be claimed would be limited to $2,600.

Where a married couple files a joint return and one spouse is age 65 or over and the other spouse is under age 65 but is receiving a public retirement system pension, the bill provides that the pension income limitation discussed above is not to apply, but rather that a further reduction in the maximum amount is to be made if the pension income of the spouse who is under 65 is less than $1,250.

The amount of the reduction is the amount by which $1,250 exceeds the amount of that spouse's public retirement system pension. For example, if the public retirement system pension of the spouse under age 65 was $1,000, the maximum initial amount for the married couple in this case would be reduced from $3,750 to $3,500 (the $2,500 available for the spouse over age 65 plus the $1,000 for the spouse under 65). If there were, in addition, $750 of social security and/or earned income in excess of the limitations, there would be a further reduction of the $3,500 to $2,750.

If a married individual under age 65 is receiving a public retirement system pension and files a separate return, the maximum amount which may be taken for purposes of the credit is $1,875. In addition, under the earned income reduction, this maximum amount where a separate return is filed is to be reduced if the individual is between 62 and 65 by one-half the amount of his earned income for the year in excess of $1,000 or, if he is under age 62, by the amount of his earned income for the year in excess of $500.

Miscellaneous provisions.-- As under present law, the bill provides that the credit for the elderly may not exceed the individual's (or the married couple's, in the case of a joint return) tax for the year. For ***5232** this purpose, however, the bill provides that the credit for the elderly is to be taken before the foreign tax credit. In other words, the tax for the year is to be computed before reduction for the foreign tax credit and the credit for tax withheld on certain tax free covenant bonds. A correlative change is made by the bill in the limitation on the foreign tax credit to reflect this reordering of the priority of these two credits. Thus, the limitation on the foreign tax credit is to be computed with respect to the tax for the year after reduction for the retirement income credit.

The bill also continues the definition of earned income which is found in present law. It further provides, however, that for purposes of computing the earned income reductions under the bill, community property laws are not to be taken into account in determining whether earned income received by a married couple is the earned income of the husband or the earned income of the wife. Accordingly, in a community property State, earned income received by the husband for personal services performed by him is to be considered entirely his earned income and not in part earned income of his wife.

In addition, as under present law, nonresident aliens are not to be eligible for the elderly credit provided by the bill.

The amendments made by the bill with respect to the retirement income credit are to apply to years beginning after December 31, 1971.

***5233** Earlier in the report, an illustrative schedule for the credit in the case of those 65 and over was shown. The schedule which follows indicates how the tax credit can be computed separately for those under age 65 who have public retirement system pensions.

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SCHEDULE S.-Credit where at least one taxpayer is under age 65 and receives pension or annuity income from public retirement systems

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***5234** IV. COSTS OF CARRYING OUT THE BILL AND VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, the following statement is made relative to the costs incurred in carrying out this bill.

A complete discussion of the costs of the social security and medicare provisions of the bill is contained in part C of section III of this report, entitled 'Actuarial Cost Estimates Under the Bill' which describes the long term financing of the amended programs and points out that under the financing provisions of the bill the programs would be fully financed. The following table set forth the estimated additional income and outgo of the social security trust funds over present law resulting from the provisions of H.R. 1, for fiscal years 1971 through 1976:

ESTIMATED ADDITIONAL INCOME AND ADDITIONAL OUTGO OF THE OASI AND DI TRUST FUNDS, COMBINED, OVER PRESENT LAW, RESULTING FROM PROVISIONS OF H.R. 1, FISCAL YEARS 1971-76

(In billions)

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

ESTIMATED ADDITIONAL INCOME AND ADDITIONAL OUTGO OF THE HI AND SMI TRUST FUNDS, OVER PRESENT LAW, RESULTING FROM PROVISIONS OF H.R. 1, FISCAL YEARS 1971-76.

(In millions)

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

A complete discussion of the costs of the proposed new assistance programs for families and adults, together with additional data relating to the programs is contained in part K of this report, entitled 'Financial and Other Data on New Assistance Programs.'

***5235** The following table sets forth the estimated costs over present law of the programs of assistance to families and adults resulting from the provisions of H.R. 1, for fiscal years 1971 through 1976.

ESTIMATED COST OF THE PROGRAMS OF ASSISTANCE FOR FAMILIES AND ADULTS, OVER PRESENT LAW, RESULTING FROM THE PROVISIONS OF H.R. 1, FISCAL YEARS 1971-76

(In billions)

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Your committee's cost estimates relating to the social security and welfare provisions of the bill, which were furnished to the committee by the Department of Health, Education, and Welfare, constitute the best information available at this time.

Your committee estimates that the liberalization of the child care deduction provided by the bill will result in an annual revenue loss of $75 million and the liberalization of the retirement income credit will result in an annual revenue loss of $375 million. The Department of the Treasury agrees with these estimates.

In compliance with clause 27(b) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the record vote by the committee on the motion to report the bill, as amended. A total of 22 votes were cast for

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reporting the bill, a total of three votes were cast against reporting the bill.

***5236** V. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill-- the '**Social Security Amendments** of 1971'-- and the table of contents.

TITLE I-PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

SECTION 101, INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS, AND IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 OR OVER

Section 101 of the bill provides a benefit increase of 5 percent effective June 1, 1972, with new minimum and maximum benefit amounts. It also increases the amount of the special payments made to certain people age 72 and older who have never worked in covered jobs or who have had less covered work than is needed to qualify for the regular retirement benefits of the program.

Primary insurance amount; column IV of the revised benefit table

Section 101(a) of the bill amends section 215(a) of the Social Security Act to substitute a new table for the present benefit table. The new table effectuates the benefit increase for people who are on the benefit rolls prior to June 1972 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in or after that month. The new primary insurance amounts, shown in column IV of the table, represent an increase of 5 percent over the primary insurance amounts provided in present law for average monthly earnings up to $750-- the highest average monthly earnings possible under present law. (The primary insurance amount is the monthly benefit payable to a worker who retires at or after age 65 or to a disabled worker who had not previously been entitled to a reduced old-age benefit; it is also the amount on which all other benefits are based.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 94.51 percent of the first $110 of average monthly earnings, plus 34.38 percent of the next $290, plus 32.12 percent of the next $200. Benefits in the table in present law approximate 90.01 percent of the first $110 of average monthly earnings plus 32.74 percent of the next $290, plus 30.59 percent of the next $150, plus 35.96 percent of the next $100, plus 20 percent of the next $100.

The primary insurance amounts provided by the new table range from a minimum of $74 for people whose average monthly earnings are $76 or less to a maximum of $331.20 for people who have average monthly earnings of $850. Average monthly earnings as high as $850 will become possible in the future under the $10,200 contribution and benefit base which the bill (in sec. 105) provides. The primary insurance amounts of workers getting benefits based on present law (i.e., workers who will not have the advantage of the increased contribution and benefit base) are raised from $70.40 to $74 at the minimum and from $275.80 to $289.60 at the maximum payable in 1972.

The total monthly amounts of benefits payable to families on the basis of a single earnings record, shown in column V of the new table, ***5237** are 5-percent higher than the amounts shown in column V of the present benefit table. The maximum family benefits are equal to 1 1/2 times the worker's primary insurance amount in the case of primary insurance amounts below $149.70, and range up to about 1.88 times the worker's primary insurance amount at a primary insurance amount of $214.80. From a primary insurance amount of $216.50 to the maximum primary insurance amount of $331.20 the maximum family benefit is graded down slightly, but not below 1.75 times the worker's primary insurance amount. This formula produces, at the maximum possible average monthly earnings of $850, a maximum family benefit of about two-thirds of the average monthly earnings. Under the bill, the maximum amount of monthly benefits payable to a family will range from $111.00 to $579.60.

Maximum family benefits

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Section 101(b) of the bill amends section 203(a)(2) of the Act to assure an increase in total family benefits for families on the benefit rolls in May 1972 if two or more persons were entitled to benefits for January 1971 or any prior month. Under the bill, the total benefits payable to such a family for June 1972 may not be reduced to less than the larger of (1) the family maximum specified in column V of the new table, or (2) the amount equal to the sum of all the benefits of family members on the benefit rolls in May 1972, increased by 5 percent. Families who came on the benefit rolls after January 1971 will get the 5-percent increase without a special provision because the maximum amount applicable to the family is increased in column V of the new benefit table. However, without the provision made by this section, families who came on the benefit rolls before February 1971 could receive little or no increase in benefits as a result of the 5-percent benefit increase effective June 1972.

Provision for determining a primary insurance amount

Section 101(c) of the bill amends section 215(a) of the Act to reorganize the provision for determining an individual's primary insurance amount, and to make permanent the provision for determining the primary insurance amount of a person who is getting a disability insurance benefit in the month before the month in which he becomes entitled to an old-age insurance benefit, attains age 65, or dies in cases where a benefit increase is effective for the month in which he becomes entitled to an old-age benefit, attains age 65, or dies.

Average monthly earnings: column III of the revised benefit table

Section 101(d) of the bill amends section 215(b)(4) of the Act so that Column III of the new benefit table will be applicable only in the case of an average monthly earnings computation for a person (1) who becomes entitled to old-age or disability insurance benefits in or after June 1972, or (2) who dies in or after that month without having been entitled to old-age or disability benefits, or (3) whose benefit is recomputed for months beginning with or after that month.

Primary insurance amount under the **social security amendments** of March 17, 1971; column II of the revised benefit table

Section 101(e) of the bill amends section 215(c) of the Act to provide that a person who becomes entitled to old-age or disability insurance benefits before June 1972, or who dies before that month, will have his primary insurance amount determined under the provisions ***5238** of present law for purposes of column II of the revised table. Since benefit amounts appearing in column II of the revised table will be converted to the new benefit amounts in column IV of that table, the effect of this provision is that people already on the rolls will have their benefits converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II of the benefit table shows the primary insurance amounts in effect prior to the **social security amendments** enacted March 17, 1971, and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Recomputation of benefits

Section 101(f) of the bill amends section 215(f)(2) of the Act to make a conforming change in the recomputation section to take account of the revision in section 215(a) made by section 101(c) of the bill.

Increase in special age-72 payments

Section 101(g)(1) of the bill amends section 227 of the Act to increase from $48.30 to $50.80 the monthly amount payable to transitionally insured workers and widows who qualify for special payments under section 227 on the basis of 3, 4, or 5 quarters of coverage. (To qualify for regular retirement benefits, a worker has to have a minimum of 6 quarters of coverage.) It also raises from $24.20 to $25.40 the amount payable to the wives of men who qualify for benefits under that section.

Section 101(g)(2) of the bill amends section 228 of the Act to increase from $48.30 to $50.80 the monthly amount payable to people who qualify under section 228 on the basis of no quarters of coverage, or of some quarters of coverage but not enough

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to qualify for either regular retirement benefits or payments to transitionally insured people, and to increase from $24.20 to $25.40 the monthly amount payable to a wife when both husband and wife are entitled to benefits under that section.

Effective date

Section 101(h) of the bill provides that the benefit increases under section 101(a) will be effective for monthly benefits for and after June 1972 and for lump-sum death payments where death occurs in or after that month, and that the increases in special payments under section 101(g) will be effective with respect to monthly payments for and after June 1972.

SECTION 102. AUTOMATIC ADJUSTMENTS IN BENEFITS, THE CONTRIBUTION AND BENEFIT BASE, AND THE EARNINGS TEST

Section 102 of the bill provides for automatic adjustments in social security benefits on the basis of increases of 3 or more percent in the Consumer Price Index. It also provides for automatic adjustment in the contribution and benefit base and in the exempt amount of earnings under the retirement test on the basis of increases in average taxable wages.

Adjustments in benefits

Section 102(a)(1) of the bill amends section 215 of the Social Security Act by adding at the end thereof a new subsection (i) providing for automatic ***5239** adjustments in benefits.

The new section 215(i)(1) defines ‘base quarter‘ as the second calendar quarter of 1972 and of any subsequent year, or any calendar quarter in which a legislated benefit increase is effective; and defines ‘cost-of-living computation quarter‘ as a base quarter in which the average Consumer Price Index exceeds by 3 or more percent the average of the Index for the latest of (1) the second calendar quarter of 1972, (2) the last prior cost-of-living computation quarter, or (3) the most recent effective quarter of a legislated benefit increase. A cost-of-living computation quarter cannot occur in a calendar year in which a legislated benefit increase was enacted or became effective.

The new sections 215(i)(2)(A) and (B) provide that if the Secretary determines that a base quarter is a cost-of-living computation quarter, he is to increase benefits, including special age-72 benefits (but not including the special minimum benefits provided under section 103 not including the special minimum benefits provided under section 103 of the bill), for the following January, by the percentage increase in the Consumer Price Index since the last cost-of-living computation quarter or, if later, the last quarter in which a legislated benefit increase became effective.

The new section 215(i))2)(C) provides that if the Consumer Price Index for a month is 2.5 or more percent higher than it was for the most recent quarter in which a legislated increase became effective, or, if later, the most recent cost-of-living quarter, the Secretary is to report the increase to the House Ways and Means and Senate Finance Committees; and, if a cost-of-living computation quarter occurs, he is to report to those Committees by August 15 the amounts of the projected increase in benefits and in the contributions and benefit base, the extent to which the cost of the benefit increase would be met by the base increase, the actuarial estimates of the effect of the increases, and the assumptions and methodology used.

The new section 215(i)(2)(D) provides that if a cost-of-living computation quarter occurs, the Secretary is to publish in the Federal Register by November 1 the amount of the increase and a new benefit table taking account of the increase. This section describes in detail the method to be used in preparing the new benefit table.

The new section 215(i)(2)(E) prohibits an automatic benefit increase if a legislated benefit increase is enacted or becomes effective during the calendar year in which the determination (on which the increase would be based) is made.

The new section 215(i)(3) defines ‘general benefit increase under this title ‘ as a legislated increase (and not an automatic increase) in all primary insurance amounts (including the combined earnings primary insurance amounts provided under section 110 of the bill but excluding the new special minimum primary insurance amounts) on which benefits are based.

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Section 102(a)(2)(A) of the bill amends section 203(a) of the Social Security Act (effective January 1, 1973) to provide that maximum family benefits shall be based on the figures in the revised benefit table in effect at the time.

Section 102(a)(2)(B) of the bill amends section 203(a)(2) of the Act (effective January 1, 1973) to assure an increase in total family ***5240** benefits for families on the benefit rolls in the months before the effective month of a cost-of-living (or general) benefit increase if two or more persons were entitled to benefits for January 1971 or any prior month. Under the bill, the total benefits payable to such a family for such effective month may not be reduced to less than the largest of (1) the family maximum specified in column V of the new table, (2) the largest total amount previously determined for the family under section 203(a), or (3) an amount equal to the sum of all the benefits of family members on the benefit rolls in the month before the benefits of family members on the benefit rolls in the month before the effective month of the benefit increase, increased by a percentage equal to the percentage of the increase provided under such benefit increase. Families who came on the benefit rolls after January 1971 will get future benefit increases without a special provision because the maximum amount applicable to the family is increased in column V of each new table. However, without the provision made by this subsection, families who came on the benefit rolls before February 1971 could receive little or no increase in benefits.

Section 102(a)(3)(A) of the bill amends section 215(a) of the Act (effective January 1, 1974) so that the provisions for determining a primary insurance amount from the table of benefits in subsection (a) will also be applicable to the table prepared under the provisions of subsection (i) of such section to effectuate a cost-of-living benefit increase.

Section 102(a)(3)(B) of the bill amends section 215(b)(4) of the Act (effective January 1, 1974) so that column III of the new benefit table will be applicable only in the case of an average monthly earnings computation for a person (1) who becomes entitled to old-age or disability insurance benefits in or after the month in which a new table becomes effective, or (2) who dies in or after that month without having been entitled to old-age or disability benefits, or (3) whose benefit is recomputed for months beginning with or after that month.

Section 102(a)(3)(C) of the bill amends section 215(c) of the Act (effective January 1, 1974) to provide that a person who becomes entitled to old-age or disability insurance benefits for a month before the month in which a new table becomes effective, or who dies before that month in which a new table becomes effective, or who dies before that month, will have his primary insurance amount for such month determined under column II of the revised table. Since benefit amounts appearing in column II of the revised table will be converted to the new benefit amounts in column IV of that table, the effect of the provision is that people who get benefits based on a primary insurance amount in column II will have their benefits based on the higher primary insurance amount appearing on the same line in column IV of the new table beginning with the effective month of the benefit increase. Under section 101(a) of the bill, column II of the new benefit table shows the primary insurance amounts in effect prior to January 1971, and column IV of the table shows the amounts to which the primary insurance amounts in column II will be converted beginning with June 1972 as a result of the 5-percent benefit increase.

Section 102(a)(4) of the bill amends sections 227 and 228 of the Social Security Act (effective January 1, 1974) to provide that special age-72 payments would be the larger of the present amounts effective for June 1972 and the most recent higher amounts established by a cost-of-living benefit increase.

***5241** Adjustments in contribution and benefit base

Section 102(b)(1) of the bill amends title II of the Social Security Act by adding at the end thereof a new section providing for automatic adjustments in the contribution and benefit base.

The new section 230(a) provides that when the Secretary publishes the amount of a benefit increase in the Federal Register by November 1 of any year, he shall also publish the amount of the base increase which will be effective the following January unless in the interim, amendments are enacted which prohibit such automatic increase in the base.

The new section 230(b) provides that the new base will be the larger of: (1) the base in effect in the year in which the determination of a base is being made, and (2) the product of the base already in effect and the ratio of the average of taxable wages in the first calendar quarter of the calendar year in which the determination was made and such average for the first calendar quarter of 1972 or, if later, the first calendar quarter of the last calendar year in which an increase in the base was enacted or a determination resulting in an automatic increase in the base was made. The product determined under clause (2)

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is to be rounded to the nearest multiple of $300 or, if it is a multiple of $150 but not of $300, to the next higher multiple of $300.

The new section 230(c) provides that the base for years after 1972 will be $10,200 (reflecting the increase made by section 105 of the bill) until the first year thereafter for which the base is increased by either an automatic increase provided by this section or a law enacted after this Act.

Adjustments in Earnings Test

Section 102(c) of the bill amends section 203(f) of the Act by adding a new paragraph (8) to provide for automatically increasing, as earnings levels rise, the exempt amount of earnings. Such section 203(f) at present establishes the level of the exempt amount which, when multiplied by the number of months in a beneficiary's taxable year, determines the amount of earnings that the beneficiary under age 72 may have in the year and still receive full benefits. Under the amendments to section 203(f) made by section 111 of the bill, this exempt amount for taxable years ending after 1971 is $166.66 2/3; this is the amount that will be increased automatically as provided by the new section 203(f)(8).

The new section 203(f)(8)(A) provides that whenever the Secretary increases social security benefits due to increases in the cost of living (under the automatic adjustment procedures prescribed in section 215(i) of the Act as added by section 102(a) of the bill), at the same time he will determine and publish in the Federal Register a new exempt amount. The new exempt amount will ordinarily apply with respect to taxable years which end with the close of or after the calendar year for which the cost-of-living increase in social security benefits is effective. However, the automatic increase in the exempt amount will not be effective for any year if during the year in which the Secretary determines an automatic increase in benefits and exempt amount a law providing a general benefit increase under title II is enacted or becomes effective, or if the new section 203(f)(8)(C) applies.

***5242** The new section 203(f)(8)(B) provides that the exempt amount for each month of a year will be either the previous exempt amount or, if larger, the product of the previous exempt amount and the ratio of the average of taxable wages in the first calendar quarter of the calendar year in which the determination is made to this average for the first calendar quarter of 1972 or, if later, the first calendar quarter of the last calendar year in which an increase in the base was enacted or a determination of an increase was made. This product is to be rounded to the nearest multiple of $10 or, if it is a multiple of $5 but not of $10, to the next higher multiple of $10. It also provides that if the Secretary determines that the exempt amount is to be increased, he is to report the estimated amount of the increase to the House Ways and Means and Senate Finance Committees by August 15, indicating the new exempt amount, the actuarial estimates of the effect of the increase, and the actuarial assumptions and methodology used.

The new section 203(f)(8)(C) provides that any new exempt amount so determined will not take effect, even if the Secretary has published the new exempt amount or notified the congressional committees as required by the new section, if a law which either provides for a general benefit increase or increases the exempt amount is enacted during the year in which the exempt amount determination is made.

SECTION 103. SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT

Section 103 of the bill provides for higher benefits for those who have had coverage under social security (at relatively low earnings) for many years.

Section 103(a) of the bill amends section 215(a) of the Social Security Act to provide a special minimum primary insurance amount which will apply when it is higher than the primary insurance amount related to the worker's average monthly earnings under social security. A worker's special minimum primary insurance amount will be equal to $5 multiplied by the number of his years of coverage under the program, up to a maximum of 30 years and $150.

Section 103(a) of the bill also provides that the number of years of coverage for purposes of determining the amount of an individual's special minimum benefit for the period 1937-1950 will be determined on a presumptive basis by dividing the total wages credited to the individual for years after 1936 and prior to 1951 by $900, disregarding any fraction and limiting

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the total to 14. The number of years of coverage after 1950 will be determined on an individual year basis; each year for which the individual is credited with wages and self employment income of at least 25 percent of the contribution and benefit base will be a year of coverage.

Section 103(b) of the bill amends section 203(a) of the Act to provide that whenever an individual's monthly benefit is based on a special minimum primary insurance amount that does not appear in column IV (primary insurance amounts related to average monthly earnings) of the benefit table, the applicable maximum family benefit will be the higher of the amount in column V (maximum family benefits) of the table on the line on which the next higher primary insurance amount appears in column IV or, if larger, the largest maximum family benefit which was applicable to the family prior to February 1971.

***5243** Section 103(c) of the bill amends section 215(a)(2) of the Act to provide that when an individual who is entitled to a disability benefit based on the special minimum primary insurance amount attains age 65, dies, or becomes entitled to an old-age benefit, his primary insurance amount will be equal to the special minimum primary insurance amount on which his disability benefit was based.

Section 103(d) of the bill amends section 215(f)(2) of the Act to provide that in addition to recomputing a worker's primary insurance amount related to his average monthly earnings, additional years of coverage will be taken into account in recomputing the special minimum primary insurance amount. Both recomputations are necessary because both primary insurance amounts remain as continuing alternatives for benefit purposes.

Section 103(e) of the bill provides the method to be used in determining an individual's old-age or disability insurance benefit whenever such benefits are based alternately on a special minimum primary insurance amount and on the individual's primary insurance amount related to his average earnings. Such benefits would be increased by the amount of the difference between the two primary insurance amounts, with such difference reduced when the individual is under age 65. This method is the same as the one used in present law when an individual's primary insurance amount related to his average monthly earnings is increased as a result of a general benefit increase or an increase resulting from a recomputation.

Section 103(f) of the bill provides that special minimum primary insurance amounts will be effective for monthly benefits for and after January 1972 regardless of when a worker became entitled to monthly benefits or died, and for lump-sum death payments in the case of deaths occurring in and after January 1972.

SECTION 104. INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

Section 104 of the bill provides increased widow's and widower's benefits for people who become entitled to such benefits after attaining age 62. A widow or widower who first becomes entitled to benefits at or after age 65 can get a benefit equal to 100 percent of the primary insurance amount of the deceased worker if the worker had not received a reduced old-age benefit before his death. A widow's or widower's benefit amount will be actuarially reduced by 19/40 of 1 percent per month for each month for which the benefit is paid between ages 60 and 65, so that at age 62 the benefit amount will be 82.9 percent of the worker's primary insurance amount and at age 60 it will be 71.5 percent. However, if the deceased worker had, at any time, received actuarially reduced benefits, the benefit amount of the surviving spouse may not be more than the larger the amount of the benefit the deceased worker would be getting if he were alive or 82 1/2 percent of his primary insurance amount.

Section 104(a)(1) of the bill amends section 202(e)(1) of the Social Security Act to provide that a widow cannot become entitled to widow's benefits if she is entitled to an old-age insurance benefit that is equal to or greater than her deceased husband's primary insurance amount, rather than an old-age insurance benefit equal to or greater than 82 1/2 percent of his primary insurance amount as under present law. The section also provides that based only on her own earnings the ***5244** wife's benefits in the case of a widow who is between ages 62 and 65 and who is not entitled to a benefit on the basis of only her own earnings, will be automatically converted to widow's insurance benefits. A woman who is entitled to an old-age benefit (or disability benefit) and a wife's benefit and whose husband dies while she is between ages 62 and 65, must choose whether to take the reduced widow's benefit or wait until age 65 to take it. Mother's insurance benefits will be automatically converted to widow's benefits at age 65.

Section 104(a)(2) of the bill amends section 202(e)(2) of the Act to provide that, subject to actuarial reduction and the

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provision for benefits for widows who remarry after age 60, the amount of a widow's benefit will be 100 percent of the deceased worker's primary insurance amount, except that if the deceased worker was, at any time, entitled to an actuarially reduced old-age benefit, the widow's insurance benefit after any actuarial reduction will not be more than the larger of the amount of the benefit the deceased worker would have been getting if he were still living, or 82 1/2 percent of the worker's primary insurance amount.

Section 104(b)(1) of the bill amends section 202(f)(1) of the Act to provide that a widower cannot become entitled to a dependent widower's benefit if he is entitled to an old-age insurance benefit that is equal to or greater than his deceased wife's primary insurance amount, rather than an old-age insurance benefit equal to or greater than 82 1/2 percent of her primary insurance amount as under present law. It also provides that reduced husband's benefits will be automatically converted to widower's insurance benefits if the widower is age 65 or over at the time of his wife's death or if the widower was under age 65, getting a reduced husband's benefit, and was not entitled to a benefit on the basis of his own earnings or on the basis of such earnings combined with those of his wife. A man who is entitled to an old-age benefit or disability benefit based only on his own earnings and a husband's benefit and whose wife dies while he is between ages 62 and 65 must choose whether to take the reduced widower's benefit or wait until age 65 to take it.

Section 104(b)(2) of the bill amends 202(f)(3) of the Act to provide that subject to actuarial reduction and the provision for benefits for widowers who remarry after age 62, a widower's benefit will be 100 percent of the deceased wife's primary insurance amount, except that if the wife was, at any time, entitled to an actuarially reduced old-age insurance benefit, the widower's insurance benefit will not be more than the larger of the amount of the benefit the deceased wife would have been getting if she were still living or 82 1/2 percent of the wife's primary insurance amount.

Sections 104(c)(1) and 104(c)(2) of the bill amend section 203 of the Act to eliminate the application of the retirement test to disabled widows and widowers until age 65, when the widow's or widower's benefit based on a disability is converted to an aged widow's or widower's benefit.

Section 104(d) of the bill amends section 202(k)(3)(A) of the Act to provide that where an individual is entitled to a benefit on the basis of his own earnings and to a widow's or widower's benefit, the widow's or widower's benefit, after any applicable reduction to take account of the family maximum provisions and for age, will be reduced to take account of the reduced benefit of the deceased spouse. The widow's or ***5245** widower's benefit will then be further reduced by the amount of the old-age or disability benefit (reduced for age where applicable).

Section 104(e)(1) of the bill amends section 202(q)(1) of the Act to provide for widows and widowers a new actuarial reduction factor of 19/40 of 1 percent per month from age 60 to 65 and 43/240 of 1 percent per month from age 50 to 60. This change in the actuarial reduction factor for disabled widows and widowers provides benefits between ages 50 and 60 equal to those provided under present law. The benefit payable at age 50 equals 50 percent of the deceased worker's primary insurance amount.

Section 104(e)(2) of the bill amends section 202(q)(7) of the Act to revise (in the light of the other amendments made by section 104) the description of the periods over which old-age, wife's husband's, widow's and widower's benefits are actuarially reduced, and to provide for a recomputation of benefits at age 62 and at age 65 to adjust the number of months in the period over which benefits are actuarially reduced. This adjustment is necessary to eliminate the reduction for months when actuarially reduced benefits were not received-- for example, when benefits were withheld because of earnings from work. Under present law this recomputation is only provided for widows and widowers at age 62 and for other beneficiaries at age 65.

Section 104(e)(3) of the bill amends section 202(q)(9) of the Act to change the definition of retirement age for widows and widowers to age 65 as is now the case of old-age, wife's, and husband's insurance benefits.

Section 104(f) of the bill amends section 202(m) of the Act to provide that the benefit of a sole surviving beneficiary prior to any reduction because of entitlement to another type of benefit under 202(k)(3) (as amended by the bill) will not be less than the minimum primary insurance amount in the benefit table.

The amended section 202(m) provides in paragraph (2), which deals specifically with the benefit for a sole surviving widow

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or widower, that such benefit after reduction for age will not be less than $70.40 if the person is first entitled to the benefit at age 62 or later and that, if the person is first entitled to benefits before age 62, such benefit will not be less than $70.40 reduced by the amount by which it would be reduced if retirement age for a widow or widower were age 62 rather than age 65. The maximum reduction that would apply in the latter case would be for 24 months if benefits begin at age 60.

The amended section 202(m) provides in paragraph (3) that where a person is entitled to a sole survivor widow's or widower's benefit for the month before any month (after December 1971) in which a general benefit increase is effective, the benefit will be increased by an amount derived by multiplying $70.40 by the percentage of the benefit increase with such amount reduced if she (or he) is under age 62.

Section 104(g) of the bill directs the Secretary to redetermine the amount of the widow's and widower's benefits if not determined under section 202(m) for people entitled to such benefits for December 1971 as if the amendments made by section 104 had been in effect at the time of their initial entitlement, with the redetermined amounts being effective for months after December 1971.

Section 104(h) of the bill provides that where 2 or more members of a family are entitled to benefits for December 1971 and at least one of them is a widow or widower who is entitled for January 1972 ***5246** to a benefit recomputed under under the amendments made by the section and the family maximum benefit provision applies for January 1972, the benefits for each family member for months after December 1971 will not be less than they would have been if the amendments made by section 104 had not been enacted.

Section 104(i) of the bill provides that these amendments will be effective for monthly benefits beginning with January 1972.

SECTION 105. INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 105 of the bill raises the amount of annual earnings that is subject to social security contributions and counted toward social security benefits (the contributions and benefit base) to $10,200 beginning with 1972, rather than to $9,000 beginning with 1972 as provided under present law.

Amendments to Title II of the Social Security Act

Definition of wages

Section 105(a)(1) of the bill amends section 209(a) of the Social Security Act (defining 'wages' for benefit purposes) to make the $10,200 contribution and benefit base applicable to wages paid in 1972, and to provide that the contribution and benefit base applicable to wages paid in years after 1972 will be the amount in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base).

Definition of self-employment income

Section 105(a)(2) of the bill amends section 211(b)(1) of the Act (defining 'self-employment income' for benefit purposes) to make the $10,200 contribution and benefit base applicable for taxable years beginning in 1972, and to provide that the contribution and benefit base applicable for defining self employment income in years beginning after 1972 will be the amount in effect determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base).

Quarter of coverage

Section 105(a)(3) of the bill amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining 'quarter of coverage') to provide that an individual will be credited with a quarter of coverage for each quarter of calendar year 1972 if his wages for such year equal $10,200, and for each quarter of a calendar year after 1972 if his wages for such year equal the contribution

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and benefit base then in effect as determined under section 230 of the Act (relating to automatic adjustment of the contribution and benefit base). An individual will also be credited with a quarter of coverage for each quarter any part of which falls within a taxable year beginning in 1972 in which the sum of his wages and self-employment income equals $10,200, and for each quarter any part of which falls within a taxable year beginning after 1972 in which the sum of his wages and self-employment income equal the contribution and benefit base then in effect as so determined.

***5247** Average monthly wage

Section 105(a)(4) of the bill amends section 215(e)(1) of the Act (relating to average monthly wages) to increase the maximum amount of annual earnings that may be counted in the computation of a person's average monthly wage for purposes of determining benefit amounts from $9,000 to $10,200 for calendar year 1972, and to the amount in effect for calendar years after 1972 as determined under section 230 of the Act (the section related to the automatic adjustment of the contribution and benefit base).

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 105(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining 'self-employment income' for social security tax purposes) by increasing the amount of annual self-employment income subject to social security contributions from $9,000 to $10,200 for taxable years beginning in 1972, and to the amount in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) for taxable years beginning after 1972.

Definition of wages

Section 105(b)(2) of the bill amends section 2121(a)(1) of the Code (defining 'wages' for social security tax purposes) by increasing the amount of annual wages subject to contributions from $9,000 to $10,200 for the calendar year 1972, and to the amount in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) for calendar years after 1972.

Federal service

Section 105(b)(3) of the bill amends section 3122 of the Code (relating to Federal service) to conform its provisions to the increase in the contribution and benefit base from $9,000 to $10,200 in 1972, and to the amount in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) thereafter.

Returns in the case of certain governmental employees

Section 105(b)(4) of the bill amends section 3125 of the Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) to conform its provisions to the increase in the contribution and benefit base from $9,000 to $10,200 in 1972, and to the amount in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) thereafter.

Special refunds of employee contributions

Sections 105(b)(5) and 105(b)(6) of the bill amend section 6413(c) of the Code (relating to special refunds of social security contributions paid by an employee who in any calendar year had more than one employer and had total wages in excess of the maximum which may be counted) to conform the special refund provisions to the $10,200 contribution and benefit base

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for the calendar year 1972, and ***5248** to the base in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) after 1972.

Estimated tax on self-employment income

Section 105(b)(7) of the bill amends section 6654(d)(2)(B)(ii) of the Code (relating to failure to pay estimated income tax on adjusted self-employment income) to conform to the $10,200 contribution and benefit base in 1972 and to the base in effect as determined under section 230 of the Act (relative to automatic adjustment of the contribution and benefit base) after 1972.

Benefit table extension

Section 105(c) of the bill amends section 215(a) of the Act to conform the benefit table to the increase in the contributions and benefit base to $10,200 by including average monthly earnings between $751 and $850 and include corresponding primary insurance amounts and maximum family benefits.

Effective dates

Section 105(d) of the bill provides effective dates for the changes made by the section. The amendments (relating to wages) made by sections 105(a)(1), 105(a)(3)(A), and 105(b) (except paragraphs (1)and (7) thereof) are applicable with respect to remuneration paid after December 1971; the amendments (relating to self-employment income) made by sections 105(a)(2), 105(a)(3)(B), 105(b)(1), and 105(b)(7) are applicable with respect to taxable years beginning after 1971; and the amendment made by section 105(a)(4) (relating to average monthly wages) is applicable with respect to calendar years after 1971. The amendment made by subsection (c) (relating to the extension of the benefit table) is applicable for months after December 1971.

SECTION 106. DELAYED RETIREMENT CREDIT

Section 106 of the bill provides for more equitable treatment for those old-age insurance beneficiaries who work and forego social security benefits, and whose first social security benefit is payable after age 65.

Section 106(a) of the bill amends section 202 of the Social Security Act by adding after subsection (v) a new subsection (w), which provides that if a person is first entitled to benefits payable at age 65 is not reduced for age under section 202(q) his old-age benefit (other than a benefit based on a special minimum primary insurance amount) payable without regard to this subsection will be increased by 1/12 of 1 percent of such benefit for each increment month that is, each month beginning with the month in which the person attains age 65 or, if later, January 1971, and prior to the month in which such person attains age 72, in which the person was a fully insured individual, and was not entitled to an old-age benefit or had deductions equal to his monthly benefit on account of work. Increment months will be re-determined annually and will be determined for the first time for 1971 with the increase effective for January 1972. Increment months will be counted through the month prior to the effective month of the increase. The total number of increment months for a person who attains age 72 after 1971 will be determined through the month before the month in ***5249** which he attains age 72 and the increase will be effective for the month in which he becomes age 72. This provision is applied after reduction under the maximum family provision (section 203(a) of the Act). In the case of a husband and wife who are receiving old-age benefits based on their combined earnings under section 202(a)(3) of the Act (as added by section 110 of the bill) this provision will be applied separately to the benefit of each so that the husband's increment will apply only to his combined earnings benefit and the wife's increments will apply to her combined earnings benefit.

Section 106(b) of the bill amends section 202(a) of the Act to include a conforming amendment in the provision relative to old-age insurance benefits.

Section 106(c) of the bill provides that these amendments will be applicable to old-age insurance benefits payable for months after 1971.

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SECTION 107, AGE-62 COMPUTATION POINT FOR MEN

Section 107 of the bill provides for determining the number of years to be used in figuring a man's insured status and the average monthly earnings on which his benefits are based by taking into account only the period up to age 62, as is the case for women rather than the period up to age 65 as under present law.

Section 107(a) of the bill amends section 214(a)(1) of the Social Security Act to provide that the benefit eligibility of a male worker will be based on the number of years up to the year in which he attains age 62. Under the law in effect prior to this amendment, benefit eligibility of a male worker was based on the number of years up to the year in which he attains age 65.

Section 107(b) of the bill amends section 215(b)(3) of the Act to provide that, in determining the number of years to be used in figuring the average monthly earnings of a male worker, there will be taken into account only years up to the year in which he attains age 62. Under the law in effect prior to this amendment, years up to the year in which a male worker attains age 65 were taken into account in figuring his average monthly earnings.

Section 107(c) of the bill amends section 223(a)(2) of the Act to provide that the disability insurance benefit of a male worker will be computed as though he attained age 62 in the first month of his waiting period or, when the waiting period is waived, the first month of his entitlement to disability benefits. Elapsed years for the disability benefit computation will not include the year in which he attains age 62 or any year thereafter.

Section 107(d) of the bill amends section 223(c)(1)(Q) of the Act to make the reference to a fully insured individual therein applicable to any individual who had attained age 62 with no distinction between a man and a woman.

Sections 107(e) and 107(f) of the bill amend sections 227(a) and 227(b) of the act to make conforming changes in the transitional insured status provisions for special age-72 payments.

Section 107(g) of the bill amends sections 209(i) and 216(i)(31(A) of the Act to make certain references therein applicable to an individual who attains age 62 with no distinction between a man and a woman.

Section 107(h) of the bill amends section 303(g)(1) of the **Social Security Amendments** of 1960 to provide that the primary insurance ***5250** amount of an individual who attains age 62 before 1961 can continue to be computed under the provisions of the Act before the 1960 Amendments.

Section 107(i) of the bill amends section 3121(a) of the Internal Revenue Code of 1954 to provide that wages for social security tax purposes will not include any payment (other than sick or vacation pay) made to an employee with no distinction between a man and a woman after the month in which he attains age 62 if the employee did not work for the employer in the period for which the payment is made.

Section 107(j) provides a three-step grading-in of the age-62 computation point for men.

Paragraph (1) provides that the amendments made by section 107, except for the amendment made by subsection (i) and the amendment made by subsection (g) to section 209(i), will be fully effective for men who attain or would attain age 62 after December 1973. The amendments to section 209(i) of the Act and to section 3121(a) of the Code will apply only to payments made to an employee after 1973.

Paragraph (2) reduces by 1 the number of elapsed years used in computing the benefits of a man who reaches 62 in 1972 and reduces by 2 the number of such years for a man who reaches 62 in 1973. Any benefits payable for months before 1972 will be paid based on the law in effect before enactment of these amendments.

Paragraph (3) provides that in sections 214(a)(1), 223(c)(1)(A), 209(i), and 216(i)(3)(A) of the Act and section 3121(a)(9) of the Code the number of quarters of coverage required for insured status is to be decreased by 1 for a man who reaches 62 in 1972, and by 2 for a man who reaches 62 in 1973.

SECTION 108. ADDITIONAL DROP-OUT YEARS

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Section 108 of the bill provides for shortening the period over which earnings are averaged for purposes of determining benefits for those who worked regularly under the social program for many years.

Section 108(a) of the bill amends section 215(b)(2)(A) of the Social Security Act to provide for 1 additional year to be dropped from the period over which a person's earnings are averaged for purposes of determining social security benefits for each 15 years of coverage such person has under social security. The definition of a year of coverage is the same as the definition contained in the special minimum benefit provision (added by Sec. 103 of the bill), but without the limitation in that provision that the number of years of coverage cannot exceed 30.

Section 108(b) of the bill provides that this amendment will be effective for the purpose of, computing or recomputing, effective for months after December 1971, average monthly earnings of people who are born after January 1, 1910, and (1) who become entitled to old-age or disability insurance benefits after 1971, (2) who die after 1971, or (3) who were entitled to disability insurance benefits for December 1971.

***5251** SECTION 109, ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

Section 109 of the bill eliminates the provision in present law under which a person who is eligible for both an old-age insurance benefit and a wife's or husband's insurance benefit, and who files for either before age 65, is deemed to have filed for both. It also eliminates the provision in present law under which a person who gets a reduced benefit in one benefit category has any subsequent benefit the gets reduced to take account of the fact that he got the first benefit early.

Section 109(a)(1) of the bill amends section 202(b)(1)(e) and section 202(c)(1)(D) of the Social Security Act to provide that a wife or dependent husband can be entitled to a wife's or dependent husband's benefit if she (or he) is not entitled to an old age or disability insurance benefit or is entitled to such a benefit which is less than one-half of her spouse's primary insurance amount. (Under present law, such a wife or dependent husband who is entitled to an old-age or disability insurance benefit cannot be eligible for a wife's or dependent husband's benefit unless the primary insurance amount on which the old-age or disability insurance benefit is based is less than one-half of the spouse's primary insurance amount.)

Section 109(a)(2) of the bill amends section 202(b)(1)(K) and section 202(c)(1) of the Act to provide that a wife's and dependent husband's benefit eligibility will terminate when a wife or dependent husband becomes entitled to an old-age insurance benefit or disability benefit equal to or exceeding one half of the spouse's primary insurance amount.

Section 109(b)(1) of the bill amends section 202(q)(3)(A) of the Act to provide that the methods of figuring a reduction under section 202(q)(3)(B) (providing for reduced wife's or husband's benefits to take account of the receipt of an actuarially reduced old-age insurance benefit) or a reduction under section 202(q)(3)(C) (providing for reduced wife's, husband's, widow's, or widower's benefits to take account of the receipt of a reduced disability benefit) will only apply if they provide a higher benefit than would be payable if the receipt of the reduced old-age insurance benefit in section 202(g)(3)(B) or of the disability insurance benefit in section 202(q)(3)(C) were ignored. Present law will continue to be applied in cases where it would produce a higher benefit.

Section 109(b)(2) of the bill amends section 202(q)(3) of the Act by striking out subparagraph (E) (providing for the reduction of an old-age insurance benefit to take account of the prior receipt of a reduced widow's or widower's benefit), subparagraph (F), (providing for the reduction in a disability insurance benefit beginning with or after age 62 to take account of the receipt of a reduced widow's or widower's benefit), and subparagraph (G) (providing for a similar reduction in a disability insurance benefit received before age 62). The effect of these changes is to eliminate the reduction in an old-age insurance benefit or a disability insurance benefit which would be made under present law to take account of receipt of reduced widow's or widower's benefits.

***5252** Section 109(c) of the bill repeals section 202(r) of the Act, which provides that a person who is eligible in a given month for a benefit as a retired worker and also for a benefit as a spouse is deemed to have filed for both if he files for either.

Section 109(d)(1) of the bill provides that (subject to section 109(d)(2)) the amendments made by section 109(a) will be effective with respect to benefits for and after the sixth month after the month of enactment on the basis of applications filed

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in or after the month of enactment.

Section 109(d)(2) of the bill provides for a redetermination in the case of a person who became entitled to old-age insurance benefits or disability insurance benefits before attaining age 65 and before the month of the enactment of the bill and who is on the rolls in the fifth month following the month of enactment, and whose entitlement to benefits as a wife or dependent husband was prevented because of his entitlement to an old-age insurance benefit or disability insurance benefit on the basis of a primary insurance amount which was greater than one-half of his spouse's primary insurance amount. A written request must be filed for the redetermination in addition to the application for wife's or dependent husband's benefits. The redetermination will be calculated as specified in the succeeding provisions of section 109, and will be effective for and after the sixth month after the month of enactment.

Section 109(e)(1)(A) of the bill provides that (subject to the succeeding provisions of section 109) the amendments made by section 109(b) will be effective with respect to benefits for and after the sixth month after the month of enactment.

Section 109(e)(1)(B) of the bill provides that, in the case of a person who was on the rolls before the sixth month after the month of enactment, the amendments made by section 109(b) will be effective only if the person files a written request for a redetermination of his benefit amount. The written request must take the form of a request for a redetermination of the benefit amount under section 109(e)(2) in the case of a person who is simultaneously entitled to two actuarially reduced benefits and who was deemed (or, except for the fact that an application was filed, would have been deemed) under section 202(r) of the Act to have filed an application for the second such benefit; in the latter case the redetermination will apply unless the person who filed the request refuses to accept it. If the request is filed before the end of the sixth month after the month of enactment, the redetermination will be effective with respect to benefits for months beginning with such sixth month; if the request is not filed before the end of the sixth month after the month of enactment the redetermination will be effective wwth respect to benefits for and after the second month following the month in which the request is filed.

Section 109(e)(1)(C) of the bill provides that section 109(c) (eliminating the deemed filing provisions) will be effective on the basis of applications filed on or after the date of enactment of the bill.

Section 109(e)(2)(A) of the bill provides that where a person entitled to reduced benefits in the fifth month following the month of enactment was deemed (or, except for the fact that an application was filed, would have been deemed) to have filed an application for benefits in another category, and files a written request for a redetermination, the Secretary will redetermine both benefits as though there ***5253** had been no deemed filing requirement at the time the person applied for benefits.

Section 109(e)(2)(B) of the bill provides the method for redetermining benefits in cases where a person was deemed (or, except for the fact that he filed an application, would have been deemed) to have filed for one of the benefits. The smaller benefit is assumed to have been taken in the first month of the simultaneous entitlement. The larger benefit is assumed to have been taken in the month in which the redetermination is effective (or at age 65, if earlier). The amount of total benefits actually received prior to the effective month of the redetermination is measured against the amount of total benefits which would have been received if the amendments had always been in effect. The excess of the former (if any) over the latter will be recovered to the extent and in the manner provided in section 109(e)(2)(C) and (E).

Section 109(e)(2)(C) of the bill provides that an individual who requests a redetermination will be notified by the Secretary of the amount of the benefits as redetermined, the amount of the excess to be recovered, and the extent of the period over which recovery will be made. The individual will have 30 days after notification is mailed to reject the redetermination.

Section 109(e)(2)(D) of the bill provides that if the request for a redetermination is filed before the end of the sixth month following the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the sixth month after the month of enactment. If the request is filed after the sixth month after the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the second month after the month in which the redetermination is requested.

Section 109(e)(2)(E) of the bill provides that the Secretary will recover any excess in benefits paid to a person to which a redetermination applies only by withholding the amount of the monthly increase in such person's benefits resulting from the

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amendments made by sections 109(a), (b), and (c); the person can receive no less in total monthly benefits after the redetermination than he was receiving before the redetermination was effective. (If the beneficiary dies, recovery will be considered complete, and no recovery will be made from any benefit that is not increased as a result of this section or these amendments).

Section 109(f) of the bill (a saving clause) prevents any reduction in benefits for other members of a family when benefits for the sixth month after the enactment of the bill are increased by a redetermination under this section for someone who was getting benefits on the same earnings record in the month in which the redetermination is made.

SECTION 110. COMPUTATION OF BENEFITS BASED ON COMBINED EARNINGS OF HUSBAND AND WIFE

Section 110 provides for a new method of computing benefits for a couple where both members of the couple have worked regularly under the social security program.

Section 110(a) of the bill amends section 202(a) of the Social Security Act to provide that the primary insurance amounts of a couple will ***5254** be based on their combined earnings where greater total benefits result, if each member of the couple reaches age 62 after 1971, is entitled to an old-age insurance benefit or a disability benefit, and has 20 or more years of coverage under the social security program after the marriage. A couple's earnings will be combined only if each of the couple elects to have the earnings combined, and once both elect to have their earnings combined the arrangement will be permanent unless a divorce is granted or one member of the couple dies. Benefits determined under this alternative computation method will begin with the later of January 1972, the month in which the election by both is filed, or, if both of the couple do not file an election in the same month, the month in which the second election is filed. As with the special minimum primary insurance amount provision added by section 103 of the bill, a year of coverage for a year after 1950 will be a year in which the worker has earnings of at least 25 percent of the contribution and benefit base in effect in the year; and, for years before 1951, one year of coverage (up to a maximum of 14) will be presumed for each $900 of cumulative earnings in the period 1937-1950. For this purpose, a year wholly within a period of disability, which is ordinarily excluded from the computation base years (years available for averaging earnings for purposes of computing primary insurance amounts), can be a year of coverage. Each member of a couple will get a primary insurance amount equal to 75 percent of the amount derived from the combined earnings.

The earnings of the man and wife in each year will be combined and credited up to the maximum amount of annual earnings that is creditable for social security purposes for the year. Earnings that are taken into account in a recomputation of one of the couple's individual earnings can be taken into account for purposes of a recomputation of the combined earnings. The combined earnings record of a couple will be the same as the earnings record that would exist if ony one of the couple had worked and had all the earnings. Where there computation periods differ, a couple's benefit will be computed on the basis of the longer computation period. For purposes of computing or recomputing the average monthly wage based on combined earnings where one or both of the couple is entitled to a disability insurance benefit, the person entitled to the disability benefit will be deemed to have attained age 62 in the first month of the waiting period for disability benefits or in the first month of entitlement to disability benefits where the waiting period requirement is waived. Only benefits to the couple will be based on combined earnings; primary insurance amounts and benefits to children and other dependents and to survivors, and lump-sum death payments, will continue to be based on the worker's primary insurance amount related to his own average monthly earnings.

For purposes of the provisions of title II other than section 202(a), the term 'primary insurance amount' does not include a primary insurance amount based on combined earnings, but means only a primary insurance amount based on the worker's own earnings unless otherwise specified.

Section 110(b) of the bill amends section 202(e) of the Act to provide that in any case where a widow was entitled for the month before the month in which her husband died to a benefit (either old-age or disability) based on combined earnings, (1) her widow's benefit will be ***5255** based on her husband's primary insurance amount that is related to his average monthly earnings, (2) the benefit of her deceased husband will be deemed to have been based on a primary insurance amount related to his average monthly earnings, and (3) her widow's benefit after reduction (where applicable) for the family maximum provision, for her age, and to take account of a reduction in her husband's benefit, will not be less than the dollar amount that her old-age or disability combined earnings benefit would be if her husband were still living. Earnings can be combined only

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through the year of the spouse's death in determining this dollar amount guarantee; automatic and legislated benefit increases would apply to the guarantee. The guarantee ceases to apply when the widow remarries.

Section 110(c) of the bill amends section 202(f) of the Act to make changes applicable in the determination of dependent widowers' benefits which correspond to those made by section 110(b) of the bill for widows. The limit on the amount of a dependent widower's benefits to the amount his wife would have been getting based on her own earnings, and, again, a dependent widower who was getting based on her own earnings, and, again, a dependent widower who was getting benefits based on combined earnings in the month before his wife's death will be guaranteed that his widower's benefits will not be lower than this amount. The guarantee causes tw apply when the widower remarries. In recomputing the widower's benefits his earnings in the year of his wife's death can be included in the combined earnings, but years after that can be added to his own earnings record only.

Section 110(d) of the bill amends section 203(a) of the Act (relative to maximum family benefits) to provide that when a person's primary insurance amount is based on combined earnings and his entitlement has not terminated, the total of the benefits of others entitled on the basis of the person's individual earnings will be determined as though his primary insurance amount has been based on his individual earnings rather than on the combined earnings.

Section 110(e) of the bill amends section 215(a) of the Act to provide that when an individual is entitled to a disability insurance benefit based on combined earnings for the month preceding the month in which he attained age 65, dies, or becomes entitled to an old-age insurance benefit, his primary insurance amount will be equal to the primary insurance amount on which such disability insurance benefit was based.

Section 110(e) of the bill also amends section 215(a) of the Act to provide that where a person's primary insurance amount is computed on the basis of the couple's combined earnings and that person has individual earnings after 1965, his primary insurance amount related to his individual average monthly earnings will be recomputed without regard to the combined earnings provision. Such recomputations are needed (1) so that the earnings can be included in a recomputation of the combined earnings, (2) in order to be able to determine the benefit payable on the basis of the individual's own earnings when the combined earnings method no longer applies on the death of either worker or their divorce, and (3) in order to determine the dependent's benefits payable on the basis of the individual's own earnings while he is getting a benefit based on the combined earnings.

Section 110(e) of the bill also amends section 223(a)(2) of the Act to make it clear that disability benefits can be based on combined earnings.

***5256** Section 110(f) of the bill provides that the computation of benefits based on the combined earnings of a husband and wife will be effective with respect to monthly benefits for months after December 1971.

SECTION 111. LIBERALIZATION OF EARNINGS TEST

Section 111(a) of the bill amends paragraphs (1), (3), and (4)(b) of section 203(f) of the Social Security Act to increase the amount of earnings a beneficiary may have in a year and still be paid full benefits for the year. It also makes a conforming amendment in paragraph (1)(A) of section 203(h) of the Act, which requires beneficiaries to report if their earnings exceed the permissible amount in a year.

Paragraph (1) of the amended section 203(f) provides that, for purposes of the retirement test (the provision in the law under which some or all benefits are withheld when a beneficiary under age 72 has exceeded a specified amount of earnings), any earnings of a beneficiary in excess of the amount he may earn and still get full benefits for the year (the annual exempt amount) will not be charged to any month in which he did not engage in self-employment and render services for wages of more than $166.66 2/3 (instead of $140 as in present law). The effect of this change is that regardless of a beneficiary's total earnings in a year his benefits may not be withheld for any month in which he did not have wages of more than $166.66 2/3 (and did not engage in self employment).

Paragraph (3) of the amended section 203(f) provides that a person's 'excess earnings' for any taxable year will be 50 percent of his earnings in excess of $166.66 2/3 (instead of $140 as in present law) times the number of months in his taxable year.

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The effect of this change is that a beneficiary will get a benefit each month of a year if his earnings for the year do not exceed $2,000 (instead of $1,680 as under present law), and that the provision under which benefits are reduced by $1 for each $2 of earnings will apply to all earnings above $2,000 (instead of only to the first $1,200 of excess earnings).

Paragraph (4)(B) of the amended section 203(f) provides that in determining whether a beneficiary earned more in a month than $166.66 2/3 (instead of $140 as under present law) for purposes of applying the monthly exemption under paragraph (1) of such section, he will be presumed to have earned more than that amount until it is shown to the satisfaction of the Secretary that he did not do so.

Paragraph (1)(A) of the amended section 203(h) requires a beneficiary to report his earnings to the Secretary of Health, Education, and Welfare whenever he has excess earnings as defined in the amended section 203(f).

Section 111(b) of the bill provides that these amendments will be effective for taxable years ending after December 1971.

SECTION 112. EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

Section 112(a) of the bill amends section 203(f)(3) of the Social Security Act to provide that, in the year in which an individual attains age 72, earnings in and after the month in which he attains age 72 will not be counted in determining his excess earnings for such year.

***5257** Section 112(b) provides that this change will be effective for taxable years ending after December 1971.

SECTION 113. REDUCED BENEFITS FOR WIDOWERS AT AGE 60

Section 113 of the bill provides for actuarially reduced benefits for nondisabled widowers as early as age 60, as is now the case for widows. The benefit amount is to be reduced by 19/40 of 1 percent per month per month for each month the benefit is taken before age 65. (See section 104 of the bill for explanation of benefit amounts from age 62 to 65 as provided by the bill.)

Section 113(a) of the bill amends section 202(f) of the Social Security Act to provide widowers' insurance benefits for nondisabled dependent widowers at age 60 (as is now the case for widows), to provide that benefits to a widower will not terminate with the third month following the month in which his disability ceases if he attains age 60 (rather than age 62 as under present law) before the end of such third month, and to provide that widower's benefits will not terminate if a widower remarries after age 60 (rather than after age 62 as under present law).

Section 113(b)(1) of the bill amends section 203(c) of the Act and section 113(b)(2) of the bill amends section 203(f) of the Act, to provide that the retirement test is inapplicable to widowers between age 60 and 65 only if they became entitled to benefits before age 60 (i.e., on the basis of a disability) rather than before age 62 as under present law. This makes the application of the retirement test to widowers consistent with its application to widows.

Section 113(b)(3) of the bill amends section 222(b)(1) of the Act to provide that deductions from widowers' benefits for refusal to accept rehabilitation services will apply up to age 60, rather than up to age 62 as under present law, reflecting the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 113(b)(4) of the bill amends section 222(d)(1)(D) of the Act to provide for funding of rehabilitation services for widowers entitled to benefits before age 60, rather than before age 62 as under present law, reflecting the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 113(b)(5) of the bill amends section 225 of the Act to reflect the availability of nondisabled widowers' benefits as early as age 60 by providing for the suspension of widowers' benefits before age 60, rather than before age 62 as under present law, where the Secretary of Health, Education, and Welfare has information indicating that the widower has ceased to be under a disability.

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Section 113(c) of the bill provides that these amendments will be effective for monthly benefits payable for months beginning with January 1972.

SECTION 114. ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN AGE 18 AND 22

Section 114 of the bill provides child's insurance benefits to an otherwise qualified adult son or daughter if his disability has been continuous since before age 22 (rather than only if it was continuous since ***5258** before age 18 as under present law). It also provides that a person whose child's insurance benefits were terminated because his disability had ceased may, if disabled again within 7 years after such termination, become re-entitled to child's insurance benefits on the basis of disability.

Section 114(a) of the bill amends section 202(d)(1)(B)(ii) of the Social Security Act to permit the payment of child's insurance benefits to an individual under a disability which began before he attained age 22 (rather than age 18).

Section 114(b) of the bill amends section 202(d)(1)(F) and (G) of the Act to provide that entitlement to child's insurance benefits will end, for a child who is over age 18 and disabled, with the second month following the month in which he ceases to be under a disability unless he is entitled as a full-time student under age 22.

Section 114(c) of the bill further amends section 202(d)(1) of the Act by adding at the end a new sentence which provides that child's insurance benefits will not be payable to an individual in any month in which the individual engages in substantial gainful activity if his continuing entitlement to such benefits is solely by reason of disability as defined in section 223(d)(1)(B) of the Act.

Section 114(d) of the bill amends subsection 202(d)(6) of the Act to provide that (1) a child whose benefits are terminated at or after age 18 can be re-entitled to child's benefits if he is disabled (as defined in section 223(d) of the Act) before age 22 or, if he was previously entitled to child's insurance benefits by reason of being under a disability, he again becomes disabled (as defined in section 223(d) of the Act) within 84 months after his prior benefits were terminated because his disability had ceased, and (2) such re-entitlement will end with the month preceding the month in which the child dies, marries, or (in certain cases) is adopted, or with the second month following the month disability ceases unless the child is entitled as a full-time student and has not attained age 22.

Section 114(e) of the bill makes changes in section 202(s) of the Act. Section 114(e)(1) amends section 202(s)(1) of the Act to exclude persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 from the category of children aged 18-21 whose mothers are ineligible for benefits on the basis of having entitled children age 18-21 in their care. Section 114(e)(2) amends section 202(s)(2) of the Act to extend to persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 the provisions that permit a childhood disability beneficiary and which permit such other beneficiary to continue to get benefits when he marries such childhood disability beneficiary. Section 114(d)(2) also amends section 202(s)(3) of the Act to extend to the child entitled on the basis of a disability that began after age 18 but before age 22(a) the exemption from the dependency requirements in present law for husband's and widower's benefits, (2) the provisions of existing law for terminating, in the case of a male childhood disability beneficiary, benefits payable to his spouse if his benefits as a disabled child terminate because he is no longer disabled, (3) the provisions of present law that exempt a disabled child from having his benefits withheld on account of work, and (4) the provisions of present law under which a disabled child ***5259** can, upon marriage, become eligible as a wife, widow, husband, or widower beneficiary.

Section 114(f) of the bill provides that these amendments will apply with respect to monthly benefits for months after December 1971, except that in the case of an individual who is not entitled to benefits under section 202 of the Act for December 1971 they will apply only on the basis of an application filed after September 30, 1971.

Section 114(g) of the bill (a savings clause) protects beneficiaries on the old-age survivors, and disability insurance benefit rolls in December 1971, in certain cases where an individual is made eligible by this section becomes entitled to benefits for January 1972, then each member of the family who was entitled to benefits for December 1971 will get an amount no less than he would have received if the newly eligible person had not become entitled to benefits, in spite of the provisions of

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section 203(a) of the Act (relating to the limit on the total amount of benefits payable to a family). The benefit amount of the newly entitled person would be determined without regard to the saving clause.

SECTION 115. CONTINUATION OF CHILD'S BENEFITS THROUGH END OF SEMESTER

Section 115(a) of the bill amends paragraph (7) of section 202(d) of the Social Security Act by adding a new subparagraph (D), which provides that a child who reaches age 22 while he is a full-time student, and who has not received or completed the requirements for a degree from a 4-year college or university, will be deemed not to have reached age 22 until the month following the end of the semester or quarter in which he is enrolled, or, if the educational institution in which he is enrolled is not operated on a semester or quarter system, until the month following the completion of the course in which he is enrolled, or the expiration of two calendar months whichever occurs first.

Section 115(b) of the bill provides that the amendments made by section 115(a) will apply with respect to benefits payable for months after December 1971.

SECTION 116. CHILD'S BENEFITS IN CASE OF CHILD ENTITLED ON MORE THAN ONE WAGE RECORD

Section 116 of the bill provides a more equitable method of determining benefits for a child who is entitled to benefits on more than one wage record.

Section 116(a) of the bill amends section 202(k)(2)(A) of the Social Security Act to provide that a child who is entitled to a child's insurance benefit on the wages and self-employment income of more than one insured individual will get a child's insurance benefit based on the wages and self-employment income of the insured individual which results in the largest benefit for the child without application of the family maximum provision and which would not result in a decrease in the benefits of others entitled on the same wages and self-employment income after the application of the family maximum provision except that when the child cannot get benefits based on the wages and self-employment income of any insured individual ***5260** without a resulting decrease in the benefits of others entitled on the same wages and self-employment income, the benefits of the child will be based on the wages and self-employment of the insured individual with the highest primary insurance amount.

Section 116(b) provides that these amendments will be effective for monthly benefits payable for months after December 1971.

SECTION 117. ADOPTIONS BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES

Section 117 of the bill repeals the requirements in present law which a child (other than a natural child or a stepchild) who is adopted by an old-age or disability insurance beneficiary after the latter becomes entitled to benefits must meet in order to qualify for child's benefits based on the beneficiary's earnings, and establishes new requirements.

Section 117(a) of the bill amends section 202(d) of the Social Security Act by replacing the existing paragraphs (8) and (9) of section 202(d) with a new paragraph (8). The new paragraph (8) provides that a child who is adopted by an old-age or disability insurance beneficiary after the latter becomes entitled to benefits will be deemed not to be dependent on the beneficiary, as required under the Act to be eligible for child's benefits, unless the child is the beneficiary's natural child or stepchild (as under present law) or unless all of the following conditions are met: the child was legally adopted by the beneficiary in an adoption decreed by a court of competent jurisdiction within the United States; the child was living with the beneficiary in the United States and receiving at least one-half of his support from the beneficiary for the year immediately before the month in which the beneficiary became disabled or entitled to benefits; and the child had not attained the age of 18 before he began living with the beneficiary. A child who was born in the one-year period during which he would otherwise be required to have been living with and receiving at least one-half of his support from the beneficiary would be deemed to meet the 'living-with' and support requirements if he was living with the beneficiary in the United States and receiving at least one-half of his support from the beneficiary for substantially all of the period occurring after the child was born.

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Section 117(b) of the bill provides that the amendments made by section 117(a) will be applicable with respect to child's benefits, on the basis of applications filed in or after the month in which the bill is enacted, for months after December 1967 if the application is filed before the end of the sixth month after the month in which the bill is enacted, but will be applicable for any month before the month of enactment if the application is filed after the end of such sixth month.

SECTION 118. CHILD'S INSURANCE BENEFITS NOT TO BE TERMINATED BY REASON OF ADOPTION

Section 118 of the bill provides for continuing the payment of a child's benefits if he is adopted in those cases where benefits are stopped under present law. Under present law, a child's entitlement to benefits ends if he is adopted unless he is adopted by (1) his natural parent, ***5261** (2) his natural parent's spouse jointly with the natural parent, (3) the worker (e.g., a stepparent) on whose earnings the child is getting benefits, or (4) a stepparent, grandparent, aunt, uncle, brother, or sister after the death of the worker on whose earnings the child is getting benefits.

Section 118(a) of the bill amends section 202(d) of the Social Security Act to eliminate adoption of a child (regardless of by whom the child is adopted) as an event which terminates the child's benefits.

Section 118(b) of the bill provides that the amendment made by section 118(a) will be effective with respect to months beginning with the month of enactment.

Section 118(c) of the bill provides that any child whose benefits were terminated by reason of his adoption prior to the date of the enactment of the bill, and who except for the adoption would be entitled to benefits for months after the month of enactment, may, upon filing an application after the date of enactment of the bill, become reentitled to benefits for months after the month of enactment.

SECTION 119. BENEFITS FOR CHILD BASED ON EARNINGS RECORD OF GRANDPARENT

Section 119(a) of the bill amends section 216(e) of the Social Security earnings, under certain circumstances, for a grandchild who was living with and being supported by the grandparent when he retired, became disabled, or died.

Section 119 of the bill provides benefits based on a grandparent's security Act (relating to definition of child) by adding a new clause (3), which provides that the term 'child' will include an individual's or his spouse's grandchild or stepgrandchild if (1) neither of the child's natural or adoptive parents were living at the time the individual became disabled, or entitled to old-age or disability insurance benefits, or died, or (2) the child was adopted by the individual's surviving spouse in an adoption that was decreed by a court of competent jurisdiction within the United States, and the child's natural or adoptive parents were not living in the individual's household and contributing to the child's support at the time the individual died.

Section 119(b) of the bill amends section 202(d) of the Act to provide that a child who is a child of an individual solely by virtue of the new clause (3) of section 216(d) shall be deemed not to be dependent on such individual as is required under the Act to be eligible for child's benefits, unless (1) the child was living with the individual in the United States and was receiving at least one-half of his support from the individual for the year immediately before the month the individual became disabled, or entitled to old age or disability insurance benefits, or died, and (2) the child began living with the individual before the child reached age 18. A child who was born in the one-year period during which he would otherwise be required to have been living with and receiving at least one-half of his support from such individual would be deemed to meet the 'living-with' and support requirements if he was living with the individual in the United States and receiving at least one-half of his support from the individual for substantially all of the period occurring after the child was born.

Section 119(c) provides that the amendments made by section 119(a) and (b) will be applicable with respect to child's insurance benefits ***5262** for months after December 1971 on the basis of applications filed after the date of enactment of the bill.

SECTION 120. ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED WIVES

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Section 120 of the bill eliminates the support requirements in present law for entitlement to benefits for divorced women.

Section 120(a) of the bill amends section 202(b)(1) of the Social Security Act by removing the requirement that to get wife's benefits and otherwise qualified divorced wife must have been receiving at least one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement, or that there must have been a court order in effect for substantial contributions to her support from him.

Section 120(b)(1) of the bill amends section 202(e)(1) of the Act by removing the parallel requirement for widow's benefits.

Section 120(b)(2) of the bill makes a conforming change in section 202(e)(6) of the Act.

Section 120(c) of the bill amends section 202(g)(1)(F) of the Act by removing the support requirement for surviving divorced mother's benefits.

Section 120(d) of the bill makes these amendments effective for benefits for and after January 1972 on the basis of applications filed on and after the date of enactment of the bill.

Section 120(e) of the bill (a saving clause) provides that the entitlement to benefits of a surviving divorced mother after December 1971 under section 202(g) of the Act will not affect the amount of benefits payable to persons who were entitled to benefits based on the same earnings record for December 1971.

SECTION 121. WAIVER OF DURATION OF RELATIONSHIP REQUIREMENT FOR WIDOW, WIDOWER, OR STEPCHILD IN CASE OF REMARRIAGE TO THE SAME INDIVIDUAL

Section 121 of the bill provides a waiver of the duration-of-relationship requirement in present law for entitlement to benefits as a widow, widower, or stepchild in certain cases of remarriage.

Section 121(a) of the bill amends the heading of the section 216(k) of the social Security Act to reflect the amendments made by section 121.

Section 121(b) of the bill amends section 216(k) of the Act to provide that the duration-of-relationship requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild-- that is, the period of not less than nine months immediately prior to the day on which the worker died (except where death was accidental or in line of duty in the uniformed service, in which case the period is three months)-- shall be deemed to be satisfied in cases where the worker and his spouse were previously married, divorced, and then remarried, where the relationship existed at the time of the worker's death , and where the duration-of-relationship requirement would have been met if the worker had died on the date when he was divorced from his spouse.

Section 121(c) of the bill provides that the amendments made by the section will be effective for benefits for months after December ***5263** 1971 on the basis of applications filed in or after the month in which the bill is enacted.

SECTION 122. WAITING PERIOD FOR DISABILITY BENEFITS

Section 122 of the bill reduces the waiting period for social security benefits for disabled workers, disabled widows, and disabled dependent widowers from 6 months to 5 months.

Section 122(a)(1) of the bill amends section 223(c)(2) of the Social Security Act to provide that in the case of an individual's application for disability insurance benefits the term 'waiting period' means the earliest period of 5 (rather than 6) consecutive calendar months throughout which such individual has been under a disability.

Section 122(a)(2) of the bill further amends section 223(c)(2) of the Act to provide that the waiting period can begin not earlier than with the first day of the 17th (rather than the 18th) month before the month in which an application for disability insurance benefits is filed if the individual is insured for disability insurance benefits in such 17th month, or, if the individual

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is not insured for disability insurance benefits in such 17th month, with the first day of the first month after such 17th month in which he is so insured.

Section 122(b)(1) of the bill amends section 202(c)(6) of the Act to provide that, in the case of widow's insurance benefits based on disability, the term 'waiting period' means the earliest period of 5 (rather than 6) consecutive calendar months throughout which the widow has been under a disability.

Section 122(b)(2) of the bill further amends section 202(c)(6) of the Act to provide that, in the case of widow's insurance benefits based on disability, the waiting period can begin not earlier than with the first day of the 17th (rather than the 18th) month before the month in which an application for such benefits is filed.

Section 122(b)(3) of the bill further amends section 202(c)(6) of the Act to provide that, in the case of widow's insurance benefits based on disability the waiting period can begin not earlier than with the first day of the 5th (rather than the 6th) month before the first month of the period (as defined in section 202(e)(5) of the Act) before the end of which the widow must have become disabled in order to qualify for such benefits.

Section 122(c)(1) of the bill amends section 202(f)(7) of the Act to provide that, in the case of widower's insurance benefits based on disability, the term 'waiting period' means the earliest period of 5 (rather than 6) consecutive calendar months throughout which the widower has been under a disability.

Section 122(c)(2) of the bill further amends section 202(f)(7) of the Act to provide that, in the case of widower's insurance benefits based on disability, the waiting period can begin not earlier than with the first day of the 17th (rather than the 18th) month before the month in which an application for such benefits is filed.

Section 122(c)(3) of the bill further amends section 202(f)(7) of the Act to provide that, in the case of widower's insurance benefits based on disability, the waiting period can begin not earlier than with the first day of the 5th (rather than the 6th) month before the first month of the period (as defined in section 202(f)(6) of the Act) before the end of which the widower must have become disabled in order to qualify for such benefits.

***5264** Section 122(d) of the bill amends section 216(i)(2)(A) of the Act to provide that a 'period of disability' means a continuous period of not less than 5 (rather than 6) full calendar months during which an individual was under a disability (unless such individual was entitled to disability insurance benefits for one or more months in such period).

Section 122(e) of the bill provides that the amendments made by section 122 are to be effective with respect to applications for disability insurance benefits, applications for widow's and widower's insurance benefits based on disability, and applications for disability determinations for purposes of establishing a period of disability which are filed in or after the month of enactment, or which are filed before such month if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been so given before such month but a civil action thereon is commenced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month; except that no monthly benefits may be payable or increased by reason of these amendments for months before January 1972.

SECTION 123. ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASE OF INDIVIDUALS WHO ARE BLIND

Section 123 of the bill provides that a blind individual can be insured for disability insurance benefits and establish a period of disability (disability freeze) without meeting a requirement of substantial recent covered work. Under present law, to meet this requirement a disabled worker (including a blind worker) generally needs 20 quarters of coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled. (An alternative provision takes into account that workers who are disabled while young may have been in the work force for a relatively short time.)

Section 123(a) of the bill amends section 216(i)(3) of the Social Security Act to except an individual whose disability is blindness (as defined in section 216(i)(1) of the Act) from the requirement of substantial recent covered work for purposes of qualifying for a period of disability.

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Section 123(b) of the bill amends section 223(c)(1) of the Act to except an individual whose disability is blindness from the requirement of substantial recent covered work for purposes of qualifying for disability insurance benefits.

Section 123(c) of the bill provides that these amendments will be effective with respect to applications for disability insurance benefits, and for disability determinations for purposes of establishing a period of disability, that are filed in or after the month of enactment, or before such month if either (q) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been given before such month but a civil action thereon is commenced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month; except that no monthly benefits may be payable or increased by reason of these amendments for months before January 1972.

***5265** SECTION 124. APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

Section 124 of the bill provides that a period of disability (disability freeze) can be established, and disability insurance benefits (and related dependents' benefits) can be paid, on the basis of an application filed within 3 months after the month of the death of the disabled individual.

Section 124(a)(1) of the bill amends section 223(a)(1) of the Social Security Act by adding at the end a new sentence which provides that entitlement to disability insurance benefits, in the case of a deceased individual, may be based upon an application filed within 3 months after the month in which he died.

Section 124(a)(2), (3), and (4) of the bill make conforming changes in subsections (a), (b), and (c) of section 223 of the Act.

Section 124(b) of the bill amends section 216(i)(2)(B) of the Act by adding at the end a new sentence which provides that a period of disability may begin on the basis of an application for a disability determination filed with respect to a deceased individual within 3 months after the month in which he died.

Section 124(c) of the bill provides that these amendments will apply in cases of deaths occurring after December 31, 1969. In addition it provides that where a death occurred prior to the date of enactment but after December 31, 1969, an application filed in accordance with such amendments within 3 months after the month of enactment will, for purposes of sections 202(j)(1) of the Act (relating to the retroactive life of an application for dependent's benefits) and 223(b) of the Act (relating to the retroactive life of an application for disability insurance benefits), be deemed to have been filed in the month such death occurred.

SECTION 125. WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

Section 125 of the bill amends section 224 of the Social Security Act, which provides for reduction of social security disability benefits when such benefits combined with workmen's compensation exceed 80 percent of the worker's average current earnings before disablement. Under present law, a worker's average current earnings for this purpose are the larger of (1) the average monthly earnings used for computing his social security benefits, or (2) earnings in employment or self-employment covered by social security during the 5 consecutive years of highest covered earnings after 1950, computed without regard to the limitations which specify a maximum amount of earnings creditable and taxable under social security.

Section 125(a) of the bill adds a third alternative under which average current earnings could also be computed on the basis of the worker's earnings in his best year in the period consisting of the calendar year in which he became disabled and the 5 years immediately preceding that year.

Section 125(b) of the bill extends the authority under which the Secretary under present law estimates the total of wages and self- ***5266** employment income for the highest 5 years after 1950 to reflect the new alternative computation method.

Section 125(c) provides that the additional computation method for average current earnings is applicable to the monthly

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benefits of all present and future beneficiaries for months after December 1971.

SECTION 126. WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

Section 126(a) of the bill amends section 229(a) of the Social Security Act to provide noncontributory wage credits, in addition to credit for basic service pay, for service performed as a member of a uniformed service (as defined in section 210(m) of the Act) after 1956 and before 1968. It also amends section 229(a) of the Act to provide that for years after 1956 the amount of the noncontributory wage credits will be $300 for each calendar quarter in which the serviceman was paid covered wages on a contributory basis for his serviceman was paid covered wages on a contributory basis for his military service. (Under present law, the amount of the noncontributory wage credits for periods of covered wages from military service after 1967 is limited to $100 for any calendar quarter in which his service pay in the quarter was $100 or less, $200 for any calendar quarter in which his service pay was more than $100 but not more than $200, and $300 in any other case.) Additional benefits paid as a result of these additional credits will be financed from general revenues in the same manner as are the benefits resulting from the noncontributory credits previously provided for military service performed after 1967.

Section 126(b) of the bill provides that the amendments made by section 126(a) will apply with respect to monthly benefits payable under title II of the Act for months after December 1971 and to lump-sum death payments in the case of deaths after December 1971. Any person on the benefit rolls in the month of enactment whose monthly benefits can be increased as a result of the noncontributory wage credits provided under section 126(a) can have his benefits increased if he or any other person entitled to monthly benefits on the same earnings record files a request for a recalculation of benefits. The calculated benefit amount will be effective for months beginning with January 1972, or, if later, the twelfth month before the month in which the request for a recalculation of benefits is filed. Recalculation of benefits to take into account the wage credits provided under section 126(a) will be made notwithstanding the limitations on recomputations contained in section 215(f)(1) of the Act (in general, benefits cannot be recomputed unless there were earnings after 1965), and no such recalculation will be regarded as a recomputation for purposes of section 215(f).

SECTION 127. OPTIONAL DETERMINATION OF SELF-EMPLOYMENT EARNINGS

Section 127(a)(1) of the bill amends section 211(a) of the Social Security Act by adding a new sentence to extend to certain self-employed people the opportunity (similar to that accorded farmers under present law) to report two-thirds of their gross income from nonfarm self-employment, up to a total of $1,600, instead of their actual net earnings for the year. This option will be available only to a self-employed person who is regularly self-employed or who is regularly ***5267** a member of a partnership. A regularly self-employed person whose net earnings from nonfarm self-employment in a taxable year are less than two-thirds of his gross income from his trade or business and are also less than $1,600 may, at his option, report for social security purposes as his net earnings from self-employment for the year two-thirds of his gross income (if his gross income from self-employment is under $2,400), or $1,600 (if his gross income from self-employment is $2,400 or more). No person may use this optional method of determining his net earnings from self-employment for more than five taxable years. If a person uses the option for both farm and nonfarm self-employment, he may not report more than $1,600 as his total net earnings from self-employment.

Section 127(a)(2) of the bill adds to section 211 of the Act a new subsection (g), to define when any person is engaged in self-employment on a regular basis for purposes of using the optional method of determining his net earnings from self-employment. Under the new subsection (g), a person would meet the definition if he had actual net earnings of $400 or more than self-employment (including his distributive share of the net income or loss from any partnership of which he is a member) in each of two out of three consecutive taxable years immediately preceding the year for which he elects to use the optional method of determining his net earnings from self-employment.

Section 127(b)(1) of the bill amends section 1402(a) of the Internal Revenue Code of 1954 to conform, for purposes of the tax on self-employment income, to the amendment made by section 127(a)(1) of the bill to section 211(a) of the Act.

Section 127(b)(2) of the bill adds to section 1402 of the Internal Revenue Code of 1954 a new subsection (i), containing a definition of regularity of self-employment for purposes of the tax on self-employment income conforming to the definition contained in the new subsection (g) of section 211 of the Act as added by section 127(a)(2) of the bill.

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Section 127(c) of the bill provides that these amendments will apply with respect to taxable years beginning after 1971.

SECTION 128. PAYMENTS BY EMPLOYER TO SURVIVOR OR ESTATE OF FORMER EMPLOYEE

Section 128(a) of the bill amends section 209 of the Social Security Act by adding a new subsection (n) to exclude from the definition of wages any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which the employee died.

Section 128(b) of the bill makes a conforming change in section 3121(a) of the Internal Revenue Code of 1954, relating to the definition of wages for purposes of the Federal Insurance Contributions Act.

Section 128(c) of the bill provides that these amendments are to apply in the case of any payment made after December 1971.

***5268** SECTION 129 COVERAGE FOR VOW-OF-POVERTY MEMBERS OF RELIGIOUS GROUPS

Section 129 of the bill provides social security coverage for services performed by members of religious orders who are under a vow of proverty in the exercise of the duties required by their order, in cases where the order or an autonomous subdivision thereof irrevocably elects coverage for its entire active membership by filing a certificate of election with the Internal Revenue Service. Under existing law services performed by a member of a religious order in the exercise of the duties required by the order are excluded from ‘employment‘ under section 210(a)(8)(A) of the Social Security Act.

Section 129(a)(1) of the bill amends section 210(a)(8)(A) of the Act to provide that service performed by a member of a religious order who has taken a vow of poverty in the exercise of the duties required by the order will constitute employment for social security purposes if the order (or autonomous subdivision thereof) has made an election of social security coverage under section 3121(r) of the Internal Revenue Code of 1954.

Section 129(a)(2) of the bill makes a conforming change in section 3121(b)(8)(A) of the Internal Revenue Code of 1954, for purposes of the Federal Insurance Contributions Act.

Section 129(b) of the bill amends section 3121 of the Code by adding a new subsection (r). The new section 3121(r)(1) provides that a religious order whose members are required to take a vow of poverty, or any autonomous subdivision of such an order, may file a certificate with the Internal Revenue Service electing to extend social security coverage to the services performed by its members in the exercise of the duties required by such order or subdivision. The certificate of election by the religious order or autonomous subdivision must specify that the election of coverage will be irrevocable; that the coverage will apply to all current and future members of the order or subdivision that all services performed by a member of the order or subdivision in the exercise of duties required by the order or subdivision will be deemed to have been performed as an employee of the order or subdivision; and that the religious order or subdivision will pay the tax on employees imposed by section 3101 of the Code and the tax imposed on employers by section 3111 of the Code, with respect to the wages of each active member.

The new section 3121(r)(2) provides that a member of a religious order is any individual who is subject to a vow of poverty as a member of the order, who performs task usually required (and to the extent usually required) of an active member of the order, and who is not considered retired because of old age or disability.

The new section 3121(r)(3) provides that the order or subdivision may elect to have the coverage begin on the first day of the calendar quarter in which the certificate of election is filed, or the first day of the following quarter, or the first day of any of the 20 quarters preceding the quarter in which the certificate of election is filed. It also provides that if the order or subdivision elects an effective date earlier than the first day of the quarter in which the election is filed, the coverage can apply only to services performed during the retroactive period by a person who was an active member when the services were ***5269** performed and who is alive on the first day of the quarter in which the certificate of election is filed. Finally, it provides that the date for filing the Federal Insurance Contributions Act returns and paying the taxes for quarters in the retroactive period without incurring penalties and interest under section 6651 of the Code will be the last day of the month

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following the quarter in which the certificate of election is filed, and that the period for assessing the taxes will not expire before the end of the 3 years after that last day.

The new section 3121(r)(4) provides that a religious order or subdivision which elects coverage of services of its members must also provide coverage for its lay employees. If the order or subdivision has in effect a waiver of exemption filed pursuant to section 3121(k) of the Code to provide coverage of its lay employees, it must amend the waiver to make it irrevocable. If the order or subdivision does not have in effect a waiver of exemption under section 3121(k) it must file an irrevocable certificate of waiver of exemption, to become effective no later than the date on which the certificate of election becomes effective. Any waiver of exemption required by the new section 3121(r)(4) must be filed under section 3121(k), notwithstanding the provisions of section 3121(k)(3) which otherwise prohibit the filing of a waiver of exemption if the organization had previously terminated an earlier waiver of exemption.

Section 129(c)(1) of the bill amends section 209 of the Social Security Act to provide that, for purposes of that Act, the wages of a member of a religious order for which a certificate of election of coverage under section 3121(r) of the Code is in effect will include the fair market value (but not less than $100 a month of any board, lodging, clothing, and other perquisites furnished to the member by the order or subdivision, or by any person or organization under an agreement with the order or subdivision.

Section 129(c)(2) of the bill makes a conforming change in section 3121(i) of the Code for purposes of the Federal Insurance Contributions Act.

SECTION 130. SELF-EMPLOYMENT INCOME OF CERTAIN INDIVIDUALS TEMPORARILY LIVING OUTSIDE THE UNITED STATES

Under existing law, the term ‘net earnings from self-employment‘ for purposes of section 211(a) of the Social Security Act and section 1402(a) of the Internal Revenue Code of 1954 means gross income, with certain exceptions, as computed under the provisions of the Code, derived by an individual from any trade or business which he carries on, less the allowable deductions attributable to such business. Section 911 of the Code provides an exclusion from gross income of up to $20,000 ($25,000 in certain instances) of earned income derived by a U.S. citizen who is either a bona fide resident of a foreign country or physically present in a foreign country or countries for 510 days (about 17 months) out of a period of 18 consecutive months.

Section 130(a) of the bill amends section 211(a) of the Social Security Act by adding a new paragraph (10) to provide that this $20,000 exclusion will not be applicable in determining net earnings from self-employment for social security purposes if the individual involved has been a resident of the United States during the entire taxable year.

***5270** Section 130(b) of the bill makes a conforming change in section 1402(a) of the Internal Revenue Code of 1954 by adding a new paragraph (11). The amendment makes no changes in the provisions for computation of net earnings from self-employment for income tax purposes.

Section 130(c) of the bill provides that these amendments will apply with respect to taxable years beginning after December 1971.

SECTION 131. COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

Section 131(a) of the bill provides social security coverage for service performed in the employ of a Federal Home Loan Bank. The **Social Security Amendments** of 1956 amended section 210(a)(6)(B))ii) of the Social Security Act and section 3121(b)(6)(B)(ii) of the Internal Revenue Code of 1954 to provide such coverage subject to the condition that the Banks coordinate their retirement systems with social security and that the plan for coordination be submitted to and approved by the Secretary of Health, Education, and Welfare by July 1, 1957. This condition was not met, and service for Federal Home Loan Banks has never been covered for social security purposes. Under section 131)a1, coverage is effective for all service performed in the employ of a Federal Home Loan Bank beginning with the first day of the first calendar quarter which begins on or after the date of enactment of the bill, and, for persons in the employ of such a Bank on such a first day, is effective for

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service performed in the employ of such a Bank after the last day of the sixth calendar year preceding the year in which the bill is enacted, but only if both the employee and employer contributions specified in the Federal Insurance Contributions Act for all such persons are paid (as provided in section 3122 of the Internal Revenue Code of 1954) by July 1, 1972, or later if agreed to before such date by the Banks and the Secretary of the Treasury or his delegate.

Section 131(b) of the bill repeals subparagraphs (A)(i) and (B) of section 104(i)(2) of the **Social Security Amendments** of 1956, which contained the condition that the FHLB retirement systems must be coordinated with social security and approved by the Secretary of Health, Education, and Welfare by July 1, 1957.

Section 132 of the bill amends section 218(p)(1) of the Social Security Act to add the State of Idaho to the list of States specifically named in the law as States which may modify their section 218 agreements to provide coverage under the social security program for policemen and firemen who are in positions under a State or local retirement system. (Section 218(p)(2) of the Act, added by the **Social Security Amendments** of 1967, makes social security coverage available to firemen who are members of a retirement system in States not listed in section 218(p)(1), but only if special conditions are met.) The effective date of such coverage would be whatever date is specified by the State of Idaho in the modification of its agreement, but could not be earlier than the beginning of the fifth year before the year in which the coverage is arranged.

***5271** SECTION 133. COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

Section 133 of the bill permits the State of New Mexico, notwithstanding the provisions of section 218 of the Social Security Act, to modify its coverage agreement with the Secretary of Health, Education, and Welfare at any time prior to the first day of the fourth month services of employees of a hospital which is an integral part of a political subdivision to which the coverage agreement has not been made applicable. The employees of such hospital would be covered as a separate coverage group as defined in section 218(b)(5) of the Act; such coverage is to apply only to service performed for a hospital which has, prior to 1966, withdrawn from a retirement system which had been applicable to the employees of such hospital.

SECTION 134. COVERAGE OF CERTAIN EMPLOYEES OF THE GOVERNMENT OF GUAM

Section 134(a) of the bill amends section 210(a)(7) of the Social Security Act by adding a new subparagraph (E) to provide social security coverage for service (except service performed by an elected official or member of the legislature or service performed in a hospital or penal institution by a patient or inmate thereof) performed in the employ of the Government of Guam by an employee properly classified as a temporary or intermittent employee whose services are not covered under a retirement system established by the Government of Guam. Where service performed in the employ of the Government of Guam is not covered by the civil service retirement provisions of title 5, United States Code, or by any other retirement system established by a law of the United States, the service will be deemed not to be performed in the employ of the United States (or any agency or instrumentality thereof) and all remuneration paid for such service will be deemed to have been paid by the Government of Guam.

Section 134(b) of the bill makes a conforming change in section 3121(b)(7) of the Internal Revenue Code of 1954.

Section 134(c) of the bill provides that these changes are to apply with respect to service performed on and after the first day of the first calendar quarter which begins on or after the date of enactment of the bill.

SECTION 135. COVERAGE EXCLUSION OF STUDENTS EMPLOYED BY NONPROFIT ORGANIZATIONS AUXILIARY TO SCHOOLS, COLLEGES, AND UNIVERSITIES

Section 135(a)(1) amends section 210(a)(10)(B) of the Social Security Act to exclude from social security coverage services performed by students, who are enrolled and regularly attending classes at a school, college, or university if such services are performed in the employ of an organization described in section 509(a)(3) of the Internal Revenue Code of 1954 (describing certain nonprofit organizations with tax-exempt status), and if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection ***5272** with such school, college, or university,

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unless it is a school, college, or university of a State or a political subdivision thereof and the services performed in its employ by a student referred to in section 218(c)(5) of the Act are covered under the agreement between the Secretary of Health, Education, and Welfare and such State entered into pursuant to section 218 of the Act.

Section 135(a)(2) makes a conforming amendment to section 3121(b)(10)(B) of the Internal Revenue Code of 1954.

Section 135(b) provides that these amendments are to apply to services performed after December 31, 1971.

SECTION 136. PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN SOCIAL SECURITY ACCOUNT NUMBER

Section 136(a) of the bill amends section 208 of the Social Security Act by adding a new subsection (f) to provide that the penalties in present law for certain fraudulent representations to the Secretary of Health, Education, and Welfare will apply to an individual who willfully, knowingly and with the intent of deceiving the Secretary as to his true identity (or the true identity of any other person) furnishes false information with respect of any information required by the Secretary in connection with the establishment and maintenance of the social security records of wages and self-employment income.

Section 136(b) of the bill provides that this amendment is to apply in the case of information furnished to the Secretary after the date of enactment of the bill.

SECTION 137. GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

Section 137(a) of the bill amends section 203(a) of the Social Security Act to add a permanent saving clause to guarantee that when a worker is getting an actuarially reduced benefit and his primary insurance amount is increased, the total benefits payable to the family on his earnings record will not be decreased. In some cases, if the benefits payable to a family are subject to the maximum limitation on the total amount of benefits payable on one earnings record, the family might, without such a saving clause, get less in total benefits after the worker's primary insurance amount is increased than they were getting before.

Section 137(b) makes permanent a special temporary saving clause provided by section 1002(b)(2) of the **Social Security Amendments** of 1969. Section 1002(b)(2) provided that where a person was on the benefit rolls in 1970 he, or his family, will never get less than he or they would have gotten prior to the 15-percent benefit increase provided by the 1969 Amendments as long as the person on the rolls in 1970 remains on the rolls. Under the change, the no-loss guarantee will apply permanently; i.e., it will apply without regard to whether the person on the benefit rolls in 1970 remains on the rolls.

SECTION 138. INCREASE OF AMOUNTS IN TRUST FUNDS AVAILABLE TO PAY COSTS OF REHABILITATION SERVICES

Section 138 of the bill amends section 222(d)(1) of the Social Security Act to increase the amount of trust fund monies that may be expended to reimburse State agencies for costs of vocational rehabilitation ***5273** services provided disability beneficiaries. The total amount made available may not exceed 1 percent of the previous year's disability benefits in the fiscal year ending June 30, 1971 (as under present law), 1.25 percent in the fiscal year ending June 30, 1972, and 1.5 percent in the fiscal year ending June 30, 1973, and thereafter.

SECTION 139. ACCEPTANCE OF MONEY GIFTS MADE UNCONDITIONALLY TO SOCIAL SECURITY

Section 139 of the bill provides authority for the Managing Trustee of the social security trust funds to accept money gifts and bequests made to the funds or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of the funds or any activity financed by the funds.

Section 139(a) of the bill amends section 201(a) of the Social Security Act to include, among the amounts that the Federal Old-Age and Survivors Insurance Trust Fund is to consist of, gifts and bequests made to that fund.

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Section 139(b) of the bill amends section 201(b) of the Act to include, among the amounts that the Federal Disability Insurance Trust Fund is to consist of, gifts and bequests made to that fund.

Section 139(c) of the bill further amends section 201 of the Act by adding a new subsection (i), which authorizes the Managing Trustee of the social security trust funds to accept on behalf of the United States money gifts and bequests made unconditionally to such funds or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of any one or more of the funds or any activity financed through the funds. The new subsection (i) also provides that any gift accepted under the authority provided by the subsection will be deposited in the specific trust fund designated by the donor, or, if no fund is designated, in the Federal Old-Age and Survivors Insurance Trust Fund.

Section 139(d) of the bill amends section 1817(a) of the Act to include among the amounts that the Federal Health Insurance Trust Fund is to consist of, gifts and bequests made to that fund.

Section 139(e) of the bill amends section 1841(a) of the Act to include, among the amounts that the Federal Supplementary Medical Insurance Trust Fund is to consist of, gifts and bequests made to that fund.

Section 139(f) of the bill provides that these amendments are to apply with respect to gifts received after the date of enactment of the bill.

Section 139(g) of the bill provides that for the purpose of Federal income, estate, and gift taxes, any gift or bequest accepted under section 201(i) of the Act will be considered a gift or bequest to or for the use of the United States and to have been made exclusively for public purposes. Consequently, such gifts or bequests would be deductible, as a contribution, from gross income for purposes of determining taxable income.

***5274** SECTION 140. PAYMENT IN CERTAIN CASES OF DISABILITY INSURANCE BENEFITS WITH RESPECT TO CERTAIN PERIODS OF DISABILITY

Section 140(a) of the bill provides that an individual who would have been entitled to disability insurance benefits under section 223 of the Social Security Act for a period which began after 1959 and ended prior to 1964 had he filed a timely application will be entitled to receive in a lump sum, as disability insurance benefits, an amount equal to the benefits which would have been payable to him for such period if he had filed a timely application. To qualify for the benefits (1) he must file an application no later than 6 months after the date of enactment of the bill, (2) prior to the date of enactment of the bill and after the date of enactment of the **Social Security Amendments** of 1967, the period for which benefits would be payable under section 140 must have been determined to be a period of disability, and (3) the application giving rise to the determination that such period is a period of disability could not have been accepted as an effective application except for the provisions of section 216(i)(2)(F) of the Act.

Section 140(b) of the bill provides that no payment may be made to any individual by reason of these provisions except upon the basis of an application filed after the date of enactment of the bill.

SECTION 141. RECOMPUTATION OF BENEFITS BASED ON COMBINED RAILROAD AND SOCIAL SECURITY EARNINGS

Section 141 of the bill amends section 215(f) of the Social Security Act (relating to the recomputation of benefits) to correct an unintended restriction arising from the **Social Security Amendments** of 1967, on the recomputation of benefits to combine railroad compensation and social security earnings.

Section 141(a)(1) of the bill amends section 215(f), of the Act, which restricts recomputations of benefits to cases where the individual has creditable earnings after 1965, to remove the reference in paragraph (2)(B) of that section to the individual whose railroad compensation and social security earnings are to be combined for social security purposes after his death.

Section 141(a)(2) of the bill further amends section 215(f) of the Act by adding a new paragraph (6) to provide that the

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primary insurance amount of a worker who died after 1967 will be recomputed to include his railroad compensation if monthly benefits or a lump sum is payable under the social security program.

Section 141(b) of the bill amends section 215(d) of the Act to permit a recomputation provided under section 215(f)(6) to be made using the simplified method for computation of the primary insurance amount, based on earnings after 1936, which was provided under the **Social Security Amendments** of 1967.

SECTION 142. CHANGES IN TAX SCHEDULES

Section 142 of the bill provides new schedules of social security tax rates for old-age, survivors, and disability insurance and for hospital insurance.

***5275** Old-age, survivors, and disability insurance rates

Section 142(a) of the bill amends sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 to provide new schedules of old-age, survivors, and disability insurance tax rates for the self-employed and for employees and employers.

Subsection (a) of the amended section 1401 provides a new schedule of tax rates for self-employment income for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Under the bill, the tax rates on self-employment income for old-age, survivors, and disability insurance are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide new schedules of tax rates on wages for purposes of old-age survivors, and disability insurance. Under present law, these tax rates for employees are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Under the bill, the tax rates on wages for both employees and employers for old-age, survivors, and disability insurance are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Hospital insurance rates

Section 142(b) of the bill amends sections 1401(b), and 3111(b) of the Code to provide new schedules of hospital insurance tax rates for the self-employed and for employees and employers.

Subsection (b) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of hospital insurance. Under present law, these tax rates are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Under the bill, the tax rates on self-employment income for hospital insurance are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide new schedules of tax rates on wages ***5276** for purposes of hospital insurance. Under present law, these tax rates are as follows:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Under the bill, the tax rates on wages for both employees and employers for hospital insurance are as follows:

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TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Effective dates

Section 142(c) of the bill provides that the amendments made by sections 142(a)(1) are to apply with respect to taxable years which begin after December 31, 1971, and that the remaining amendments made by section 142 are to apply with respect to remuneration paid after December 31, 1971.

SECTION 143. ALLOCATION TO DISABILITY INSURANCE TRUST FUND

Section 143(a) of the bill amends section 201(b)(1) of the Social Security Act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to wages and now provides that such amount with respect to any wages paid after 1969 is to be 1.10 percent of such wages. Under the amended section 201(b)(1), the amount so allocated and appropriated will be 0.90 percent of the wages paid during 1972, 1973, and 1974, 1.05 percent of the wages paid during 1975 and 1976, and 1.25 percent of the wages paid after 1976.

Section 143(b) of the bill amends section 201(b)(2) of the Act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to self-employment income and now provides that the amount to be so allocated and appropriated with respect to any self-employment income reported for taxable years beginning after 1969 is to be 0.825 percent of the amount of such self-employment income. Under the amended section 201(b)(2), the amount so allocated and appropriated will be 0.675 percent of the self-employment income so reported for any taxable year beginning after 1972 and before 1975, and 0.734 percent of the self-employment income so reported for any taxable year beginning after 1974.

TITLE II-PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

Part A-Eligibility And Payments For Benefits

Section 201. COVERAGE FOR DISABILITY BENEFICIARIES UNDER MEDICARE

Section 201 of the bill extends coverage under medicare for hospital insurance and supplementary medical insurance to social security disability beneficiaries, and disabled qualified railroad retirement ***5277** annuitants, who have been entitled to disability benefits for at least two years.

Section 201(a)(1) of the bill amends the heading of title XVIII of the Social Security Act, and the headings of parts A and B thereof, to reflect the inclusion of the disabled in the benefits provided in these parts.

Section 201(a)(2) of the bill amends section 1811 of the Act to include under the hospital insurance program individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of the Act, or under the railroad retirement system, on the basis of a disability.

Section 201(a)(3) of the bill amends section 1831 of the Act to include disability beneficiaries under the supplementary medical insurance program.

Section 201(b)(1) of the bill amends section 226(a) of the Act to include under the hospital insurance program individuals under age 65 who have been entitled for not less than 23 consecutive months to disability insurance benefits under section 223; childhood disability benefits under section 202(d); widow's insurance benefits under section 202(e) and widower's insurance benefits under section 202(f), by reasons of disability; and individuals who have been for not less than 24 consecutive months disabled qualified railroad retirement beneficiaries under section 22 of the Railroad Retirement Act of 1937. Coverage begins with the later of July 1972, or the 25th consecutive month of entitlement to disability benefits; and ends with the month in which entitlement to disability benefits ceases or, if earlier, with the month before the month of attainment of age 65.

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Section 201(b)(2) of the bill amends section 226(b) of the Act to provide that no payment is to be made under the hospital insurance program for post hospital extended care services or post-hospital home health services in the case of a disability beneficiary unless the discharge from the hospital required to qualify such services for payment occurred at a time when he was entitled to disability benefits.

Section 201(b)(3) of the bill amends section 226(b)(2) of the Act to provide that disability beneficiaries, as well as retirement and survivor beneficiaries, are to be deemed entitled to monthly insurance benefits or to be qualified railroad beneficiaries for the month of their death if they would have been entitled to such benefits for that month had they died in the following month.

Section 201(b)(4) of the bill amends section 226(c) of the Act to include in the definition of ‘qualified railroad retirement beneficiary‘ for hospital insurance program purposes certain disabled railroad retirement annuitants, as described in section 22 of the Railroad Retirement Act.

Section 201(b)(5) of the bill amends section 226 of the Act by providing that widows and widowers who become entitled to widow’s or widower’s insurance benefits by reason of disability may remain entitled to such benefits, and so to hospital insurance, until attainment of age 65; and further provides that, for hospital insurance purposes, a beneficiary entitled to widow’s or widower’s insurance benefits by reason of disability whose entitlement to such benefits ceases because of subsequent entitlement to old-age insurance benefits will be deemed to have continued to be entitled to such widow’s or widower’s insurance benefits.

***5278** Section 201(c)(1) of the bill amends section 1836 of the Act to provide for eligibility to enroll in the supplementary medical insurance program for disability beneficiaries entitled to hospital insurance benefits under part A of title XVIII.

Section 201(c)(2) of the bill amends section 1837(c) of the Act to provide that the initial enrollment period requirements of the supplementary medical insurance program are also to apply to eligible disability beneficiaries. It further amends section 1837(d) to have it conform with the inclusion of disability beneficiaries as eligible for enrollment in the supplementary medical insurance program.

Section 201(c)(3) of the bill adds a new subsection to section 1838 of the Act to provide that the coverage period (and enrollment under supplementary medical insurance) of a disability beneficiary will end with the close of the last month for which he is entitled to hospital insurance benefits.

Sections 201(c)(4) and (5) of the bill amend section 1839 of the Act to provide (1) that the month supplementary medical insurance premium for a disability beneficiary who enrolls after his initial enrollment period is to be increased by 10 percent for each full 12 months in the same continuous period of eligibility in which he could have been but was not enrolled; (2) that any such increase in an individual’s premium will not apply to any other continuous period of eligibility which he may have; and (3) that for purposes of such an increase in premium, an individual’s continuous period of eligibility is the period beginning with the first day on which he is eligible to enroll under supplementary medical insurance and ending with his death, except that any period during all of which an individual was so eligible by reason of entitlement to disability benefits and which ended in or before the month preceding the month of attainment of age 65 will be a separate ‘continuous period of eligibility,‘ and each such period which ends will be deemed not to have existed for purposes of subsequent premium increases.

Section 201(c)(6) amends section 1840 of the Act to include disability beneficiaries among other social security beneficiaries whose monthly supplementary medical insurance premiums are to be collected by deduction from their monthly benefits, and to provide for appropriate transfers of funds among the Federal Old-Age and Survivors Insurance, Disability Insurance and Supplementary Medical Trust Funds.

Section 201(c)(7) amends section 1875(a) of the Act to require the Secretary to carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the disabled, as well as that of the aged.

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Section 201(d) of the bill amends the Railroad Retirement Act of 1937 by adding a new section (section 22) providing that certain individuals entitled to annuities on the basis of disability under the Railroad Retirement Act will be entitled to hospital insurance benefits and will be eligible to enroll for supplementary medical insurance benefits under title XVIII of the Social Security Act in a like manner as those entitled to social security disability benefits. As under the Social Security Act, disabled individuals under age 65 would, before becoming covered, have to have ben entitled to disability benefits for not less than 24 consecutive months. Included are disabled railroad workers who have, or could have, been entitled to annuities on the ***5279** basis of permanent and total disability; disabled widows and widowers of railroad employees; and disabled children of railroad employees.

SECTION 202. HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER TRANSITIONAL PROVISION

Section 202 of the bill adds a new section 1818 to title XVIII of the Social Security Act.

Subsection (a) of the new section 1818 provides that a person who (1) has attained age 65, (2) is either a resident citizen or a lawfully admitted resident alien and (3) does not otherwise qualify for hospital insurance coverage will be eligible to enroll for such coverage.

The new section 1818(b) provides that enrollment for hospital insurance coverage will be as provided by regulations and during an enrollment period prescribed under this provision.

The new section 1818(c) makes the provisions of sections 1837, 1838, 1839(c) 1840(f), and 1840(h) of the Social Security Act (relating to enrollment, coverage, premium amount, and premium payment, respectively, under the supplementary medical insurance part of title XVIII) applicable for the purposes of hospital insurance coverage under the new section except that--

(1) an initial general enrollment period for an individual first meeting the eligibility requirements specified in subsection (a) on or before the last day of the seventh month after the month of enactment of the bill is to begin on the first day of the second month after the month of enactment and end on the last day of the tenth month after the month of enactment;

(2) the initial enrollment period for an individual first meeting the eligibility requirements specified in subsection (a) on or after the first day of the eighth month after the month of enactment will begin the first day of the third month before the month in which he first meets such requirements and end seven months later;

(3) the coverage period for an individual enrolling for hospital insurance benefits during the initial general enrollment period described in paragraph (1) above will begin (A) the first day of the second month following the month of enrollment, or (B) January 1, 1972, or (C) the first day of the first month in which he first meets the requirements of section 1818(a), whichever is later;

(4) termination of coverage will be effective at the end of the month following the month in which a request for termination is filed, and

(5) termination of coverage will also be effective with the month before the month an individual becomes eligible for hospital benefits under section 226 of the Social Security Act or section 103 of the **Social Security Amendments** of 1965; and in the event of such termination, the individual will be deemed to have filed in the month of such termination the application required to establish entitlement to hospital insurance benefits under such other provisions.

The new section 1818(d)(1) establishes the monthly premium for hospital insurance coverage as made available under this section at $31 for each month before July 1972.

The new section 1818(d)(2) provides that in December of 1971 and each year thereafter the Secretary is to determine and promulgate ***5280** the premium amount applicable for each month in the succeeding fiscal year, such premium to be an amount equal to $31 multiplied by the ratio of (1) the inpatient hospital deductible for the current year, as promulgated under section 1813(b)(2) of the Act, to (2) such deductible as promulgated for 1971, and rounded to the nearest $1.

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The new section 1818(e) authorizes a State or any other public or private agency or organization to contract or otherwise arrange with the Secretary to pay the monthly premiums on behalf of its employees or retirees who are eligible and have enrolled for hospital insurance protection under this section if the Secretary determines that such a method of premium payment is administratively feasible.

The new section 1818(f) provides that amounts paid to the Secretary for hospital insurance coverage under this section will be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

SECTION 203. AMOUNT OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUM

Section 203(a) of the bill amends section 1839(b)(1) of the Social Security Act by limiting the applicability of the method of premium determination provided for in section 1839(b)(2) to months before July 1972.

Section 203(b) of the bill amends section 1839(b)(2) of the Act to provide that the Secretary is to promulgate a premium as determined by paragraph (2) only in years ending on or before December 31, 1970.

Section 203(c) of the bill amends section 1839 of the Act (as amended by sections 201(c)(4) and (5) of the bill) by redesignating subsections (c), (d), and (e) as subsections (d) (e), and (f), respectively, and by adding a new subsection (c).

The new section 1839(c)(1) provides that the Secretary will, during December of 1971 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which will be applicable for the 12-month period beginning July 1 in the succeeding year. Such actuarial rate will be the amount the Secretary estimates to be necessary so that the aggregate amount for the 12 month period with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred by the Federal Supplementary Medical Insurance Trust Fund for the 12 month period with respect to such enrollees. In calculating the actuarial rate the Secretary will include an appropriate amount for a contingency margin.

The new subsection 1839(c)(2) provides that for each month after June 1972 the amount of the monthly premium of each individual enrolled under part B will be determined under section 1839(c)(3).

The new subsection 1839(c)(3) provides that the Secretary will, during December of 1971 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under part B for the 12 month period beginning July 1 in the succeeding year. The monthly premium will be equal to the smaller of the actuarial rate for enrollees age 65 and over as determined according to section 1839(c)(1) for that 12 month period, or the monthly premium rate most recently promulgated by the Secretary, multiplied by the ratio of (i) the amount in column IV of the table which as of June ***5281** 1 following the determination appears (or is deemed to appear) in section 215(a) of the Act on the line which includes the figure ‘750’ in column III of the table to (ii) the amount in column IV of the table which appeared (or was deemed to appear) in section 215(a) on the line which appeared the figure ‘750‘ in column III as of June 1 of the year in which the determination is made. Whenever the Secretary promulgates the monthly premium he will, at the same time, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at an adequate actuarial rate and in the derivation of dollar amounts specified in this paragraph.

The new subsection 1839(c)(4) provides that the Secretary will, during December of 1971 and of each year thereafter, determine the actuarial rate for disabled enrollees under age 65 which will be applicable for the 12-month period beginning July 1 in the succeeding year. Such actuarial rate will be the amount the Secretary estimates to be necessary so that the aggregate amount for the 12 month period with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred by the Federal Supplementary Medical Insurance Trust Fund for the 12-month period with respect to such enrollees. In calculating the actuarial rate, the Secretary will include an appropriate amount for a contingency margin.

Section 203(d)(1) of the bill amends section 1839(d) of the Act (as redesignated by the bill) to provide that monthly premiums as determined under section 1839(c) will be increased by 10 percent for each full 12 months in which an enrollee could have been but was not enrolled.

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Section 203(d)(2) of the bill amends section 1839(f) of the Act (as redesignated by the bill) by providing that for purposes of determining whether the premium increase applicable to late enrollees should be applied to disabled persons, the beginning of an individual's 'continuous period of eligibility ' will determine the beginning of his initial enrollment period. Each 'continuous period of eligibility' which terminates will be deemed not to have existed for purposes of subsequently applying the premium increase provision.

Section 203(e) of the bill amends section 1844(a)(1) of the Act to authorize the appropriation, to the Federal Supplementary Medical Insurance Trust Fund, of a Government contribution equal to the aggregate premiums payable for enrollees age 65 and over, multiplied by the ratio of (i) twice the dollar amount of an actuarially adequate rate per enrollee age 65 and over (as determined under section 1839(c)(1) for the month in which such aggregate premiums are deposited in the Trust Fund, minus the dollar amount of the premium per enrollee for such month, to (ii) the dollar amount of the premium per enrollee for such month. There is also authorized to be appropriated a Government contribution equal to the aggregate premiums payable for enrollees under age 65 under part B and deposited in the Trust Fund, multiplied by the ratio of (i) twice the dollar amount of an actuarially adequate rate per enrollee under age 65 (as determined under section 1839(c)(4) for the month in which such aggregate premiums are deposited in the Trust Fund, minus the dollar amount of the premium per enrollee for such month, to (ii) the dollar amount of the premium per enrollee for such month.

***5282** SECTION 204. CHANGE IN SUPPLEMENTARY MEDICAL INSURANCE DEDUCTIBLE

Section 204(a) of the bill amends section 1833(b) of the Social Security Act to increase the annual deductible applicable under the supplementary medical insurance program from $50 to $60.

Section 204(b) of the bill amends section 1835(c) of the Act to make a conforming change which permits hospitals, subject to appropriate limitations, to collect from a beneficiary only those customary charges for covered medical and other health services furnished on an out-patient basis that do not exceed the $60 annual deductible applicable under the supplementary medical insurance program.

Section 204(c) of the bill provides that the new deductible amount is to be effective with respect to calendar years after 1971, except that with respect to the deductible carryover provision of clause (1) of section 1833(b) of the Act, the new deductible will be deemed applicable as of January 1, 1971.

SECTION 205. INCREASE IN LIFETIME RESERVE DAYS AND CHANGE IN HOSPITAL INSURANCE COINSURANCE AMOUNT UNDER MEDICARE

Section 205(a) of the bill amends section 1812(a)(1) and section 1812(b)(1) of the Social Security Act (relating to the number of days of inpatient hospital services for which payment may be made) to provide for an increase from 60 to 120 in the number of days of inpatient hospital services for which an individual is entitled during his lifetime to have payment made whenever he has exhausted the 90 days of inpatient hospital services for which he is regularly entitled to have payment made during a spell of illness.

Section 205(b) of the bill amends section 1813(a)(1) of the Act to provide that the amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 61st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 30 days.

Section 205(c) of the bill provides that these amendments are to apply to inpatient hospital services furnished during inpatient hospital stays beginning after December 31, 1971.

SECTION 206. AUTOMATIC COVERAGE FOR SUPPLEMENT MEDICAL INSURANCE

Section 206(a) of the bill amends section 1837 of the Social Security Act by adding new subsections (f) and (g).

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The new subsection (f) provides that an individual (1) who is eligible under section 1836 of the Act to enroll for medical insurance coverage as a result of being entitled to hospital insurance benefits, and (2) whose initial enrollment period under section 1837(d) of the Act begins on or after the first day of the second month following the month in which the new subsection is enacted or October 1, 1971, whichever is later, will be deemed to have enrolled in the medical insurance program.

***5283** The new subsection (g) makes the provisions of section 1837 of the Act applicable for purposes of deemed enrollments except that--

(1) the initial enrollment period for an individual meeting the eligibility requirements for enrollment in the supplementary medical insurance program by reason of entitlement ot disability insurance benefits as described in section 226(a)(2)(B) of the Act will begin April 1, 1972, or the first day of the 22nd consecutive month for which such individual has been receiving disability benefits, whichever is later, and will reoccur with each continuous period of eligibility and upon attainment of age 65;

(2) (A) an individual who is receiving cash benefits under section 202 or 223 of the Act on the first day of his initial enrollment period or becomes entitled to monthly cash benefits under section 202 of the Act for any one of the first 3 months of his initial enrollment period, will be deemed to have enrolled in the third month of his initial enrollment period, and (B) a person who first becomes entitled to monthly benefits under such section 202 of the Act during the last 4 months of his initial enrollment period will be deemed to have enrolled in the month in which he files the application establishing his entitlement to hospital insurance benefits; and

(3) a person who defers establishing his entitlement to hospital insurance benefits until after the end of his initial enrollment period will be deemed to have enrolled for supplementary medical insurance coverage during the general enrollment period in effect at the time or immediately following the time at which he establishes entitlement to hospital insurance benefits.

Section 206(b) of the bill amends section 1838(a) of the Act by adding a new paragraph (3) which provides that (A) supplementary medical insurance coverage for an individual deemed to have enrolled within the first 3 months of his initial enrollment period will begin on the first day of the month such person meets the eligibility requirements of section 1836 of the Act or January 1, 1972, whichever is later, and (B) supplementary medical insurance coverage for an individual deemed to have enrolled after the first 3 months of his initial enrollment periods will be as prescribed under subparagraphs (B), (c), (D), and (E) of section 1838(a)(2) of the Act.

Subsection 206(c) of the bill amends section 1838(b) of the Act by adding a new paragraph which provides that a termination request filed by a deemed enrolled individual before the month in which his supplementary medical insurance coverage is effective will cancel such coverage and will not count as a termination for the purposes of the limitations on enrollment and reenrollment prescribed in subsection 1837(b). Such new paragraph further provides that a termination request filed by a deemed enrolled individual on or after the first day his supplementary medical insurance coverage is effective will cancel such coverage as of the last day of the calendar quarter following the quarter in which the notice is filed.

***5284** SECTION 207. ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE COMPREHENSIVE HEALTH CARE UNDER MEDICAID

Section 207(a)(1) of the bill amends section 1903 of the Social Security Act by adding new subsections (g) and (h) which will establish incentives for the use of organizations providing comprehensive health care, and disincentives for extended use of inpatient facilities.

The new section 1903(g) (in paragraph (1)) provides a 25 percent increase in the Federal medical assistance percentage, not to exceed 95 percent, for amounts paid by States after June 30, 1971, under contracts with health maintenance organizations and other facilities providing comprehensive health care. Such percentage may be increased only if such contract provides that payments for services provided under the contract will not exceed the payment level for similar services provided in the same geographical area and rendered under an approved State plan.

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The new section 1903(g) (in paragraph (2)(A) and (B)) decreases the Federal medical assistance percentage by 33 1/3 percent for inpatient services of more than 60 days in any fiscal year after June 30, 1971, furnished (A) in a general or TB hospital, or (B) in a skilled nursing home unless the State agency makes a showing satisfactory to the Secretary that there is an effective program of control over utilization. Such a showing must include evidence that (1) in each case for which payment is made, a physician certifies at the time of admission, or if later at the time the individual applies for medical assistance (and recertifies at least every sixty days and accompanied by supporting material as required by regulations), that such services are required by regulations), that such services are required for patient needs; (2) in each case services were furnished under a plan established and periodically reviewed and evaluated by a physician; (3) such State has in effect a continuing program of utilization review pursuant to section 1902(a)(30) of the Act whereby the necessity for admission and continued stay of each patient in a skilled nursing home is periodically reviewed and evaluated by medical and other professional personnel who are not themselves directly responsible for the care of the patient and who are not employed by or financially interested in any skilled nursing home.

Paragraph (2)(C) of the new section 1903(g) decreases the Federal medical assistance percentage by 33 1/3 percent for inpatient services furnished an individual in a hospital for mental diseases after he has been furnished such services for 90 days after June 30, 1971, and for up to an additional 30 days if the State agency demonstrates that such additional days would provide an opportunity for continued therapeutic improvement, with Federal payments for inpatient services furnished any individual in a hospital for mental diseases being completely eliminated after the individual has been furnished such services for a total of 365 days during his lifetime.

In determining the number of days during which an individual has received services under the new section 1903(g), days of services to which he is entitled under section 1812 of the Act are not to be counted.

The new section 1903(h)(1) authorizes the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and cost of intermediate cost facilities. If the Secretary determines for any calendar quarter after December 31, ***5285** 1971, that a reasonable cost differential does not exist between the cost of skilled nursing home and intermediate care facility services in a State, he may reduce the amount which would otherwise be considered under the State plan by the amount which would otherwise be considered under the State plan by the amount he judges to be a reasonable equivalent of the difference between costs for these types of facilities. The new section 1902(h)(2) requires the Secretary to consider the range of cost differentials in various States.

The new section 1902(h)(3) defines ‘cost differential ‘ (determined by the Secretary on the basis of data for the most recent calendar quarter for which satisfactory data are available) as the excess of the average amount paid in such State per inpatient day for inpatient skilled nursing home services over the average amount paid for such services in intermediate care facilities.

Section 207(a)(2) of the bill makes conforming changes to section 1903(a)(1) of the Act.

Section 207(b) of the bill provides that these amendments (except where otherwise stated) will be effective July 1, 1971.

SECTION 208. COST-SHARING UNDER MEDICAID

Section 208(a) of the bill amends section 1902(a)(14) of the Social Security Act to provide, effective January 1, 1972, that (A) in the case of cash assistance recipient adults or foster children or individuals meeting appropriate income and resources requirements no enrollment fee, premium, or similar charge and no deduction, cost sharing, or similar charge may be imposed for required services, and any deduction, cost sharing, or similar charge imposed for optional services must be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and (B) in the case of those adults or foster children who are not receiving aid or assistance under any such State plan and who do not meet the appropriate income and resources requirements there will be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to income and no other enrollment fee or premium may be imposed.

Section 208(b) provides that these amendments will be effective January 1, 1972 (or earlier if the State plan so provides).

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SECTION 209. DETERMINATION OF PAYMENTS UNDER MEDICAID

Section 209(a) of the bill amends section 1902(a)(10) of the Social Security Act to provide for making medical assistance available to all individuals who are receiving assistance to needy families with children as defined in section 405(b), or who are receiving assistance for the aged, blind, and disabled under title XX, or with respect to whom payments for foster care are made in accordance with section 406.

The amended section 1902(a)(10) further provides that if medical or remedial care or services are included for any group of individuals who are not receiving assistance under title XX or XXI, or for children who are members of families receiving assistance under title XXI other than needy families with children as defined in section 405(b), then medical or remedial care and services will be provided to all such individuals who would, if needy, be eligible for assistance under title XX or XXI, and who have insufficient income and resources ***5286** to meet the costs of necessary medical or remedial care. The medical or remedial care and services made available to all such individuals must be equal in amount, duration, and scope, and may not be more than the medical or remedial care and services made available to individuals receiving assistance to needy families with children (as defined in section 405(b)), to aged, blind, or disabled individuals receiving assistance under title XX, or to foster care children on whose behalf payment is made under section 406.

Section 209(b)(1) of the bill amends section 1902(a)(14) of the Act to provide that its cost-sharing provisions will apply only subject to the provisions of 1903(f) of the Act (discussed below).

Section 209(b)(2) of the bill amends section 1902(a)(17) of the Act to provide for taking into account in determining eligibility for an extent of medical assistance, only such income and resources as are available to the applicant or recipient, as determined in accordance with standards prescribed by the Secretary. Section 209(b) provides for certain additional changes to conform to the income disregard provision of section 1903(f) of the Act.

Section 209(c) of the bill amends section 1903(f) of the Act to provide that no Federal matching payments may be made for amounts expended as medical assistance in any State for an individual who is aged, blind, or disabled (as defined in title XX) and who is not receiving assistance under title XX unless the income of any such individual (after deducting medical expenses) is not in excess of the standard for medical assistance established under the State plan. It further provides that no Federal matching payments may be made for amounts expended as medical assistance in any State for any member of a family as defined in title XXI, whether or not such family is receiving assistance under that title, unless the income of all the members of such family (after deducting medical expenses) is not in excess of the standard for medical assistance so established.

The amended section 1903(f) provides that the standard for medical assistance established under the State plan may not be less than, nor more than 133 1/3 percent of, the highest amount that would be payable under title XXI to an eligible family of the same size without income or resources plus the amount of any supplementary payment made by the State in accordance with the new section 2156 of the Act to such an eligible family.

The amended section 1903(f) also provides that, in determining for these purposes the income of any individual who is aged, blind, or disabled within the meaning of title XX or the income of any family, there is to be excluded the first $1,020 per year of earned income in the case of a blind or disabled individual or the first $720 per year of earned income in the case of an aged individual or a family (or proportionately smaller amounts for shorter periods, plus other amounts that would be excluded under the income disregard provisions of titles XX and XXI.

Section 209(d) of the bill amends section 1902 of the Act by adding a new subsection (e) which provides that notwithstanding any of the above provisions no State will be required to furnish medical assistance to any individual or member of a family unless the State would be (or would have been) required to furnish such assistance to such individual or family under its Medicaid plan that was in effect on January 1, 1971. Thus, no State would be required to cover under ***5287** Medicaid persons who were made newly eligible for cash benefits under titles XX and XXI. However, if a State should elect to provide Medicaid benefits on the basis of its January 1, 1971, medical assistance standard (instead of the new standard prescribed in section 1903(f)) it would be required to incorporate a spend-down provision comparable to that contained in section 1903(f) so that any eligible individual of family would be entitled to Medicaid only if the income of such individual of family (after deducting incurred medical expenses) was not in excess of the State standard for medical assistance as in effect on January 1, 1971.

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Section 209(e) of the bill provides that these amendments will become effective on July 1, 1972.

SECTION 210. PAYMENT UNDER MEDICARE TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Section 210 of the bill amends section 1862 of the Social Security Act to exclude from coverage under title XVIII any item or service furnished any individual on or after January 1, 1975, if it is covered under a Federal employees health benefits plan, unless prior to the date on which it is furnished the Secretary has determined and certified that the health plan or the Federal employees health benefits program has been modified so as to assure that there is available to each enrolled Federal employee or annuitant, upon or after attaining age 65, one or more health benefits plans offering protection supplementing that afforded by both parts A and B or part B alone of Medicare. In addition, the Government or the plan is to make available to such Federal employee or annuitant a contribution at least equal to that which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under a government-wide plan. The contribution must be toward the supplementary protection referred to above, or to or on behalf of the employee or annuitant to offset the cost of coverage to him of parts A and B of Medicare, or it may be a combination of both of these.

SECTION 211. PAYMENT UNDER MEDICARE FOR CERTAIN INPATIENT HOSPITAL AND RELATED PHYSICIANS' SERVICES FURNISHED OUTSIDE THE UNITED STATES

Section 211(a) of the bill amends section 1814(f) of the Social Security Act to make Medicare benefits payable for inpatient hospital services furnished outside the United States in cases where the beneficiary is a resident of the United States and the foreign hospital is closer to, or substantially more accessible from, his residence than the nearest hospital in the United States which was suitable and available for his treatment. Such benefits are to be payable without regard to whether an emergency existed or where the illness or accident occurred. (In present law section 1814(f) limits payment to emergencies occurring within the United States.) Payment for covered hospital services furnished outside the United States would be made essentially on the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States.

Section 211(b) of the bill amends section 1861(e) of the Act to provide that Medicare benefits payable under the amended section ***5288** 1814(f) will be payable only with respect to inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards.

Section 211(c)(1) of the bill amends section 1862(a)(4) of the Act to make Medicare benefits payable for physician's services and ambulances services furnished in conjunction with covered foreign inpatient hospital services for the period during which such inpatient hospital services were furnished.

Section 211(c)(2) of the bill amends section 1861(f) of the Act to provide that for purposes of covered physicians' services furnished in conjunction with covered foreign inpatient hospital services, the term 'physician' includes a doctor of one of the arts specified in such section 1861(r) legally authorized to practice such art in the country in which such inpatient hospital services are furnished.

Section 211(c)(3) of the bill amends section 1842(b)(3)(B)(ii) of the Act to make benefits for physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services payable only in accordance with the itemized bill method of reimbursement.

Section 211(c)(4) of the bill amends section 1833(a)(1) of the Act to provide that, with respect to expenses incurred for physicians' services furnished in conjunction with covered foreign inpatient hospital services, the amounts paid are to be subject to such limitations as may be prescribed by regulations.

Section 211(d) of the bill provides that these amendments will be applicable to services furnished with respect to admissions occurring after December 31, 1971.

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PART B-IMPROVEMENTS IN OPERATING EFFECTIVENESS

SECTION 221. LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

Section 221(a) of the bill adds a new section 1122 at the end of title XI of the Social Security Act.

Subsection (a) of the new section 1122 expresses the congressional intent that funds appropriated under titles V, XVIII, and XIX of the Act should not be used to support unnecessary capital expenditures and that reimbursement under such titles should support State health planning activities.

Subsection (b) of the new section 1122 provides that the Secretary, after consultation with the governor (or other chief executive officer) and local public officials, is to make an agreement with any States under which a designated planning agency (which has a governing body or advisory body at least one-half of whose members represent consumer interests) will (1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility of health maintenance organization in its jurisdiction, (2) receive, and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of other qualified planning agencies with respect to proposed capital expenditures of health ***5289** care facilities or health maintenance organizations in their jurisdiction, and (3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted on opportunity for a fair hearing by such agency or person other than the designated agency as the governor (or other chief executive officer) may designate, whenever such findings indicate that any such expenditure is inconsistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans.

Subsection (c) of the new section 1122 provides that the Secretary will pay from the Federal Hospital Insurance Trust Fund to any State with which he makes an agreement the reasonable costs incurred by the planning agencies involved in preparing and forwarding findings and recommendations with respect to proposed capital expenditures.

Subsection (d)(1) of the new section 1122 provides that in determining reimbursement under title V, XVIII, and XIX of the Act the Secretary will disallow, for such periods as he finds necessary, expenses with respect to capital expenditures which are attributable to depreciation, interest on borrowed funds a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure if he determines (A) that neither the designated planning agency nor any other qualified planning agency had been notified of the proposed capital expenditure at least 60 days prior to obligation for such expenditure, or (B) that the agency had given notice to the facility within a reasonable period of time after receipt of notice of the proposed expenditures and prior to obligation for such expenditure that it would not be in conformity with the standards, criteria, or plans developed by such agency or any other qualified planning agency for adequate health care facilities in such jurisdiction, and prior to reporting its findings to the Secretary had consulted and taken into consideration the findings and recommendations of other planning agencies or organizations performing similar functions with respect to the area in which the health facility is located and granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings.

Subsection (d)(2) of the new section 1122 provides that if after submitting the matter to the national advisory council (discussed below) the Secretary determines that disallowance of any expense relating to a capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization which has satisfactorily demonstrated its ability to provide comprehensive health care services efficiently, effectively, and economically, and would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he will not disallow such expense.

Subsection (e) of the new section 1122 provides that in determining reimbursement under titles V, XVIII, and XIX in cases where facilities or equipment are obtained under lease that would have been subject to a disallowance if purchased, the Secretary is to deduct from the ***5290** facility's rental expenses an amount reasonably equivalent to that which would have

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been disallowed if the facilities or equipment had been purchased.

Subsection (f) of the new section 1122 provides that any person dissatisfied with a determination under the section may request reconsideration by the Secretary up to 6 months after notification, with such determinations not being subject to other administrative or judicial review.

Subsection (g) of the new section 1122 defines the term 'capital expenditure' as an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, and exceeds $100,000, changes the facility's bed capacity, or substantially changes the facility's services.

Subsection (h) of the new section 1122 provides that the section is not applicable to Christian Science sanatoriums.

Subsection (i)(1) of the new section 1122 directs the Secretary to establish or designate a national advisory council to assist and advise him in the preparation of regulations and on policy matters in the administration of the section.

Subsection (i)(2) of the new section 1122 provides that any council so established or designated is to consult and coordinate its activities with other appropriate national advisory councils and coordinate activities under the section with related Federal health programs.

Subsection (i)(3) of the new section 1122 provides that if an advisory council is newly established by the Secretary its members are not to be in the regular full-time employ of the United States and are to be chosen from among leaders in the fundamental sciences, the medical sciences, or the organization, delivery, and financing of health care, or from among persons who are State or local officials or are active in community affairs or public or civil affairs or who are representative of minority groups. Members of such advisory council will be entitled to compensation at rates to be determined by the Secretary but not to exceed the maximum rate paid to a GS-18.

Section 221(b) of the bill provides that the amendment made by section 221(a) will apply with respect to capital expenditures the obligation for which is incurred after June 30, 1972, or (with respect to any State or part thereof) earlier if the State so requests.

Section 221(c) of the bill amends various provisions of titles V, XVIII, and XIX of the Act to make conforming changes and to require that the standards applied under those provisions be consistent with the new section 1122.

SECTION 222. REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

Section 222(a)(1) of the bill authorizes the Secretary of Health, Education, and Welfare to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to hospitals, extended care facilities, and other providers of services under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of the Act in order to stimulate providers through positive financial incentives to use their facilities ***5291** and personnel more efficiently and thereby reduce program costs without adversely affecting the quality of services.

Section 222(a)(2) of the bill provides that such experiments and demonstration projects are to be of sufficient scope and applicability to permit a thorough evaluation of alternative methods of prospective reimbursement without committing the programs involved to the adoption of any prospective payment system either locally or nationally.

Section 222(a)(3) of the bill provides that the Secretary may waive reimbursement requirements of titles V, XVIII, and XIX with respect to such experiments and demonstration projects. Any costs incurred in such experiments or projects in excess of amounts which would normally be paid under such titles will be borne by the Secretary. The Secretary will obtain the advice and recommendations of competent specialists prior to instituting any such experiment or project.

Section 222(a)(4) of the bill provides that grants and payments for experiments and demonstration projects are to be made in

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appropriate part from the Federal trust funds established for the hospital and supplementary medical insurance programs under the title XVIII of the Act.

Section 222(a)(5) of the bill provides that the Secretary is to submit a report to the Congress no later than January 1, 1973, on the experiments and projects carried out. Such report is to include detailed recommendations with respect to programwide implementation of a system of prospective reimbursement.

Section 222(b)(1) of the bill amends section 402(a) of the **Social Security Amendments** of 1967 to provide authorization for the Secretary to develop and engage in experiments and demonstration projects for the following purposes: to determine whether changes in methods of payment (other than those authorized in section 222(a) of the bill) would create incentives for increasing efficiency and economy for health care and services under health programs established by the Social Security Act; to determine whether payments to organizations and institutions which have the capability of providing comprehensive health care, mental health care, ambulatory health care, and institutional services which may substitute, at lower cost, for hospital care for non-covered services incidental to covered services would result in a more economical provision and effective utilization of covered services to determine whether use of rates of payment approved by a State for purposes of administering one or more of its laws would reduce the costs of health programs established by the Act; to determine whether payments based on a single, combined rate of reimbursement for teaching activities and patient care rendered by residents, interns, and supervisory physicians connected with a graduate medical education program would result in more equitable and economical patient care arrangements; to determine whether areawide or community-wide peer review utilization review, and medical review mechanisms would more effectively assure that health services provided conform to appropriate professional standards that payment will be made only when such services are medically necessary, and, in the case of inpatient care, that such care cannot be effectively provided on an outpatient basis or more economically in a different type of inpatient facility; and to determine whether fixed price or performance incentive ***5292** contracts would induce more effective, efficient, and economical performance by intermediaries and carriers. Grants and payments for these experiments and demonstration projects are to be made in appropriate part from the Federal trust funds established for the hospital and supplementary medical insurance programs under title XVIII of the Act.

Section 222(b)(2) of the bill amends section 402(b) of the 1967 Amendments to make conforming changes which permit demonstration projects as well as experiments.

Section 222(c) of the bill amends section 1875(b) of the Act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report on the experiments and demonstration projects authorized under the amendments made by section 222(b) of the bill.

SECTION 223. LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE

Section 223(a) of the bill amends section 1861(v)(1) of the Act (defining reasonable cost for purposes of provider reimbursement) by excluding from recognition as reasonable any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.

Section 223(b) of the bill amends section 1861(v)(1) of the Act to provide for the establishment of limits on costs which will be recognized as reasonable based on estimates of the costs necessary in efficient delivery of services.

Section 223(c) and section 223(d) of the bill further amend section 1861(v)(1) of the Act to make it clear that the medicare objective of meeting all direct and indirect costs of providing covered services to covered individuals does not extend to those costs determined to be unnecessary in the efficient delivery of covered services.

Section 223(e) of the bill amends section 1866(a)(2)(B) of the Act to permit a provider to impose charges for items or services in excess or or more expensive than items or services for which reimbursement may be made under title XVIII even where not requested by the patient provided that (A) such charges are customarily imposed by such provider, do not exceed the excess cost of such items or services in the provider's previous fiscal period, and are identified (to the person to whom the items or services are furnished) as costs in excess of those determined to be necessary, and (B) the Secretary provides public notice that such charges may be imposed.

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Section 223(f) of the bill amends section 1861(v) of the Act (as otherwise amended by the bill) to provide for reduction of program reimbursement to providers of services in those instances where the provider imposes charges in excess of or more expensive than those determined to be necessary in the efficient delivery of health services to the extent that such charges exceed the cost actually incurred for such items or services.

Section 223(g) of the bill amends section 1866(a)(2) of the Act to provide that a provider of services may not impose additional charges upon a patient as otherwise permitted under the amendments made by section 223 if the admitting physician has a direct or indirect financial interest in such provider.

Section 223(h) of the bill provides that these amendments will be effective with respect to accounting periods beginning after June 30, 1972.

***5293** SECTION 224. LIMITS ON PREVAILING CHARGE LEVELS

Section 224(a) of the bill amends section 1842(b)(3) of the Social Security Act with respect to the determination of the reasonable charge for services furnished under the supplementary medical insurance program. Under the amendment, no charge may be determined to be reasonable in the case of bills or requests for payment submitted to be reasonable in the case of bills or request for payment submitted after December 31, 1970, if it exceeds the higher of (1) the prevailing charge recognized by the carrier for similar services in the same locality in administering the supplementary medical insurance program under part B of title XVIII on December 31, 1970, or (2) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which such bill is submitted or such request for payment is made. The prevailing charge levels determined for purposes of the latter clause for fiscal years beginning after June 30, 1972, may not exceed (in the aggregate) the levels for fiscal year 1972 except to the extent justified by economic changes as reflected in appropriate economic index data.

In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1972, and determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment are widely available in a locality only to the extent and under the circumstances specified by the Secretary.

Section 224(b) of the bill amends section 1867 of the Act to require the Health Insurance Benefits Advisory Council to conduct a study of the methods of reimbursement for physicians' services under Medicare to determine their effects on (1) physicians' fees generally (2) the extent of assignments accepted by physicians, and (3) the share of total physician fee costs which the Medicare program does not pay and which the beneficiary must assume. The Council is required to report the results of the study to the Congress no later than July 1, 1972, such report to include discussion of alternatives to the present methods and a recommendation as to the preferred method.

Section 224(c) of the bill amends section 1903 of the Act by adding a new subsection (i) providing that payment to States under the Medicaid program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1971, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

Section 224(d) of the bill amends section 506 of the Act by adding a new subsection (f) providing that payment to States under the maternal and child health program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1971, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

***5294** SECTION 225. LIMITS ON PAYMENT FOR SKILLED NURSING HOME AND INTERMEDIATE CARE FACILITY SERVICES

Section 225 of the bill amends section 1903 of the Social Security Act by adding a new subsection (j) to limit payments for skilled nursing homes and intermediate care facilities.

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The new section 1903(j)(1) limits the amount payable to a State under its plan for skilled nursing home services in any calendar quarter after December. 31, 1971, to no more than the product of (A) the number of inpatient days of skilled nursing home services provided under the State plan in each quarter and (B) 105 percent of the average per diem cost of such services for the fourth calendar quarter preceding the quarter in question.

The new section 1903(j)(2) limits the amount payable to a State with respect to intermediate care facility services provided in any calendar quarter after December 31, 1971, to no more than the product of (A) the number of inpatient days of intermediate care facility services provided under the State plan or plans in such quarter, and (B) 105 percent of the average per diem cost of such services for the fourth calendar quarter preceding the quarter in question.

With respect to both skilled nursing homes and intermediate care facilities, the Secretary is authorized to increase the specified percentage limitation to take account of increases in per diem costs which result directly from increases in the Federal minimum wage or from other changes in Federal law.

SECTION 226. PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Section 226(a) of the bill adds to title XVIII of the Social Security Act a new section 1876 providing for payments to health maintenance organizations.

Paragraph (1) of the new section 1876(a) authorizes the Secretary to determine by actuarial methods a prospective per capita rate of payment to health maintenance organizations with which he has entered into a contract. Payments are to be made (A) for services provided under parts A and B of title XVIII to individuals who are enrolled in such organizations and are also entitled to hospital insurance benefits under part A and enrolled for medical benefits under part B, and (B) for services provided under part B to individuals who are enrolled in such organizations and who are not entitled under part A but are enrolled under part B. These payments are in lieu of amounts that would otherwise be payable with respect to such individuals under sections 1814(b) and 1833(a) of the Act.

Paragraph (2) of the new section 1876(a) provides, in subparagraph (A), that the rate of payment to a health maintenance organization will be determined annually in accordance with regulations established by the Secretary. The rate will be equal to 95 percent of the amount the Secretary estimates would be payable if the services were furnished by sources other than a health maintenance organization. (The rate would be adjusted to assure actuarial equivalence and would be derived from an estimated amount which includes administrative costs incurred by fiscal intermediaries and carriers.)

Subparagraph (B) of the new paragraph (2) provides that, in order to assure that such organizations will not be permitted to retain ***5295** revenues exceeding expenses of such enrollees at a rate greater than the rate retained for other enrollees, the Secretary is to require, following each accounting period, at a time and in such form and detail as he may prescribe, that (i) the organization submit a certified public statement for the preceding accounting period of the amount retained and rate of retention for individuals enrolled with the organization under the new section, considered as a group, and for all other enrollees of the organization, considered as a group; (ii) an audit be conducted, in accordance with regulations of the Secretary, of any such organization whose rate of retention for individuals enrolled under this section exceeds 90 percent of the organization's rate of retention with respect to other enrollees of the organization; and (iii) any part of the amount retained by the organization with respect to individuals enrolled under this section which represents an excessive rate of retention must be repaid by such organization unless used by it to provide to enrollees under this section benefits in addition to those covered under parts A and B of title XVIII or to reduce premium rates charged by the organization to individuals enrolled under the section. Subparagraph (B) also defines for purposes of the new section (iv) the term 'amount retained' as the difference between the organization's revenues (regardless of source) for any accounting period, with respect to any group of enrollees, and the organization's expenses for such period with respect to that group; (v) the term 'rate of retention' as the ratio of the amount retained to revenues, expressed as a percentage; and (vi) the term 'excessive rate of retention' as either the organization's rate of retention for individuals enrolled under the section which exceeds that organization's rate of retention with respect to all other enrollees or, if such organization has been exempted from the requirement that one-half of its enrolled population be under age 65, a rate of retention which exceeds a reasonable rate of retention determined in accordance with regulations which take into account the rate of retention experienced by comparable organizations with respect to other enrollees.

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Paragraph (3) of the new section 1876(a) provides that the payment to health maintenance organizations for enrollees under the section who are entitled under part A and enrolled under part B of title XVIII is to be made from the Federal hospital insurance trust fund and the Federal supplementary medical insurance trust fund. The portion of such payment to be made from the supplementary medical insurance trust fund to a health maintenance organization for a month will be equal to 200 percent of the sum of (A) the number of such enrollees who are at least age 65 multiplied by the monthly actuarial rate for beneficiaries enrolled under part B who have attained age 65 (as determined under the new section 1839(c)(1)), and (B) the number of such enrollees who are under the age 65 multiplied by the actuarial rate for the beneficiaries enrolled under part B who are under age 65 (as determined under the new section 1839(c)(4)). The remainder of the monthly payment will be paid from the hospital insurance trust fund. Payment would be subject to the limitation on Federal participation for capital expenditures as provided in section 1122 of the Act as added by section 221 of the bill.

***5296** The new section 1876(b) defines a 'health maintenance organization as a public or private organization which--

(1) provides, directly or through arrangements with others, health services to enrolled individuals on a per capita prepayment basis;

(2) provides to enrolled individuals, either directly or through arrangements with others and through qualified providers of services, all of the services and benefits covered under parts A and B of title XVIII;

(3) provides physicians' services directly through physicians who are either employees or partners of the organization or under arrangements with one or more groups of physicians organized on a group or individual practice basis) which is (or are) reimbursed for services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physicians in any such group are paid on a fee-for-service or individual practice basis;

(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically;

(5) subject to the provision of the new section 1876(h), has enrolled members at least half of whom are under age 65;

(6) assures that the health services required by its members are received promptly and appropriately and that the services received measure up to quality standards which it establishes under regulations prescribed by the Secretary and

(7) has an open enrollment period at least once every year under which it accepts eligible individuals, without restrictions, except as may be provided in regulations, on a first-come first-accepted basis up to the limit of its capacity.

The new section 1876(c) provides that the benefits provided to an individual through a health maintenance organization will consist of--

(1) for those individuals enrolled in accordance with the new section 1876(e) who are entitled under part A and enrolled under part B, (A) services described in sections 1812 and 1832 of the Act which are furnished by such organizations, and (B) emergency services (as defined in regulations) or such other services which, in accordance with the new section 1876(f), it has been determined that the individual was entitled to receive from the health maintenance organization; and

(2) for those individuals enrolled in accordance with the new section 1876(e) who are enrolled under part B but not entitled under part A, the services described in clause (1) above, but only to the extent that the services are also described under section 1832 of the Act.

The new section 1876(d) provides that (subject to the provisions of section 1876(e)) every individual who is entitled to hospital insurance benefits under part A and who is enrolled for medical insurance benefits under part B or who is enrolled under part B but not entitled under part A will be eligible to enroll with a health maintenance organization which serves the geographic area in which he resides.

***5297** The new section 1876(e) provides that regulations are to be prescribed to govern enrollment and termination of

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enrollment with a health maintenance organization.

The new section 1876(f) provides that an individual enrolled with a health maintenance organization is entitled to a hearing before the Secretary (to the same extent as is provided in section 205(b) of the Act) if the amount in controversy is $100 or more and the individual is dissatisfied because of his failure to receive without additional cost any health service to which he believes he is entitled. In any such hearing the Secretary will make the health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, the individual or the health maintenance organization will be entitled to judicial review of the Secretary's final decision (after hearing as provided in section 205(g) of the Act).

Paragraph (1) of the new section 1876(g) provides that if the health maintenance organization provides only the services described in section 1876(c), its premium rate may not exceed the actuarial value of the cost sharing provisions applicable under part A and part B.

Paragraph (2) of the new section 1876(g) provides that if the health maintenance organization provides additional services it will furnish its enrollees with information as to the division of its premium rate between the portion for the additional services and the portion for the services described in section 1876(c). The latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and B.

The new section 1876(h) permits the Secretary to waive, in the case of any health maintenance organization, for up to 3 years, the requirement in section 1876(b)(5) that at least half of the organization's enrolled members be persons under 65, where the organization is making continuous efforts toward complying with such requirement.

Paragraph (1) of the new section 1876(i) authorizes the Secretary to contract with any health maintenance organization which undertakes to provide on a per capita prepayment basis to those individuals enrolled pursuant to subsection (e), all services covered under part B and, for those individuals who are also entitled to hospital insurance benefits, all services covered under part A of title XVIII.

Paragraph (2) of the new section 1876(i) provides that such contracts are to be for a minimum of one year, as determined by the Secretary, and (subject to three exceptions) automatically renewable in the absence of notice by either party of intention to terminate at the end of the current team. The exceptions are that the Secretary may terminate the contract any time (after giving reasonable notice and opportunity for hearing to the affected organization, in accordance with regulations) upon finding that the organization (A) has failed substantially to carry out the contract, or (B) is carrying it out in a manner inconsistent with efficient and effective administration of this section, or (C) no longer substantially meets the definition of health maintenance organization prescribed in section 1876(b).

Paragraph (3) of the new section 1876(i) provides that the effective date of any contract under the section is to be specified in the contract pursuant to regulations.

Paragraph (4) of the new section 1876(i) provides that each contract executed under the section must authorize the Secretary (or his designee) (i) to inspect or otherwise evaluate the quality, appropriateness, ***5298** and timeliness of services performed under the contract, and (ii) to audit and inspect any books and records of the organization pertaining to services performed and determination of amounts payable under the contract. Such contracts will also contain other terms not inconsistent with the new section which are deemed necessary by the Secretary.

The new section 1876(j) provides that the Secretary, in carrying out the contractual functions prescribed in subsection (i), may disregard any provision of law or regulation relating to the making, performance, amendment, or modification of contracts of the United States upon determining that such provision is inconsistent with the purposes of title XVIII of the Act.

Section 226(b) of the bill provides that notwithstanding the provisions of section 1814 and section 1833 of the Act, any organization which has entered into a contract pursuant to section 1876 will receive Medicare reimbursement only as provided in that section for individuals who are members of such organization. However, the Secretary may reimburse such organization on the basis of a per capita rate, determined in accordance with the provisions of section 1876(a), with appropriate actuarial adjustments for the utilization of out-of-plan services, for individuals who were members of such organization prior to January 1, 1972, and who, although eligible, chose not to have payments made pursuant to section 1876.

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Such reimbursement would be for a period not to exceed three years, beginning with January 1, 1972.

Section 226(c)(1) and (2) of the bill amends sections 1814(a) and 1833(a) of the Act to make conforming changes.

Section 226(d) of the bill provides that these amendments are to be effective with respect to services provided on or after January 1, 1972.

SECTION 227. PAYMENT UNDER MEDICARE FOR SERVICES OF PHYSICIANS RENDERED AT A TEACHING HOSPITAL

Section 227(a) of the bill amends section 1861(b) of the Social Security Act, with respect to the definition of the term 'inpatient hospital services.' It strikes out the second sentence of 1861(b) (relating to coverage of inhospital services furnished by interns or residents-in-training under certain approved teaching programs) and adds new paragraphs (6) and (7) to include as inpatient hospital services the medical and surgical services of

(6) an intern or resident in training under a teaching program approved by the Council on Medical Education of the American Medical Association the Committee on Hospitals of the Bureau of Professional Education of Professional Education of the American Osteopathic Association or the Council on Dental Education of the American Dental Association, and

(7) a physician teaching under such an approved program unless (A) the patient receiving inpatient services is a private patient (as defined in regulations) or (B) the hospital establishes that during the 2-year period ending December 31, 1967, and all subsequent years all inpatients were billed and attempts were made to collect reasonable charges in full for such physicians' services, and substantial payment (including deductible and coinsurance amounts) was regularly collected from at least 50 percent of all inpatients.

***5299** Section 227(b)(1) of the bill amends section 1814(a) of the Act to make conforming changes in the exceptions to the usual requirements of requests and certifications for payment.

Section 227(b)(2) of the bill further amends section 1814 of the Act by adding a new subsection (g) which provides that payment for the services of teaching physicians which are reimbursed on an equivalent cost basis (as described in the new subparagraph (D) of section 1861(b)(1) of the Act) may be made to a fund designated by the organized medical staff of the hospital or, if the services were furnished by the faculty of a medical school, by such faculty if (1) the hospital is a participating provider of services and (2) there is written assurance that such payment will be used by the fund for improved hospital care or for educational or charitable purposes and that no charges are retained for such services.

Section 227(c) of the bill amends section 1861(v)(1) of the Act (relating to definition of reasonable cost) to make conforming changes and to add to two new subparagraphs (C) and (D). The new subparagraph (C) provides that where the faculty of a medical school provides services which would be reimbursable under part A of title XVIII if furnished directly by the hospital or which are reimbursable under part B of title XVIII, the reasonable cost of such services to the medical school will be included in determining the reasonable cost to the hospital of furnishing such services if the hospital pays to the medical school the reasonable costs of such services. Subparagraph (D) provides that where physicians furnish services that are either inpatient hospital services covered under part A of title XVIII or hospital services covered under part B of title XVIII and the hospital (or medical school under arrangement with the hospital) incurs no actual cost in furnishing these services, the reasonable cost will be deemed to be the cost the hospital or medical school would have incurred if it had paid a salary to the physicians equivalent to the average salary paid to all physicians employed by the hospital or (if only a minimal number of no physicians are employed by the hospital) by similar hospitals in a geographic area large enough to assure that a sufficient number of physicians are included in determining such average salary.

Section 227(d)(1) of the bill amends section 1861(v) of the Act to make a conforming change relating to the making of reasonable cost payments for certain hospital services furnished by physicians to a designated fund.

Section 227(d)(2) amends section 1866(a)(1) of the Act to make an additional conforming change.

Section 227(e)(1) of the bill amends section 1832(a)(2)(B) of the Act to include as hospital services covered under part B of

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title XVIII physicians' services rendered by a resident or intern of the hospital or a physician teaching under an approved program, unless such services would be excluded as inpatient hospital services under paragraph (7) of section 1861(b) as revised above.

Subparagraph (A) of section 227(e)(2) of the bill amends section 1835(a) of the Act to make a conforming change.

Subparagraph (B) of section 227(e)(2) of the bill amends section 1835 of the Act by adding a new subsection (e) providing that where services provided by teaching physicians are covered under part B of title XVIII as hospital services and are reimbursed on an equivalent ***5300** salary basis (as described in the new subparagraph (D) of section 1861(v)(1) of the Act), payment may be made to a fund designated by the organized medical staff of the hospital or, if the services were furnished by the faculty of a medical school by such faculty, under the same conditions as set forth for part A payment above.

Section 227(f) of the bill amends section 1861(q) of the Act to make a conforming change.

Section 227(g) of the bill provides that these amendments are to apply with respect to accounting periods beginning after June 30, 1971.

SECTION 228. ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE

Section 228(a) of the bill amends section 1814 of the Social Security Act (as otherwise amended by the bill) by adding New subsections (h) and (i).

Paragraph (1) of the new section 1814(h) provides that where (A) a patient's physician completes the certification for post-hospital extended care services (as required by subparagraph (C) of section 1814(a)(2) of the Act), prior to or at the time of admission to an extended care facility, (B) the certification describes a medical condition of the patient which is designated in regulations, (C) a plan of treatment for providing the services accompanies the certification, and (D) there is compliance wi h additional requirements and procedures prescribed in regulations, the individual will be presumed to require, for purposes of payments to the extended care facility (subject to the limitations of section 1812 of the Act), the care described in subparagraph (C) of section 1814(a)(2) of the Act, but only during such limited periods of time with respect to such conditions of individuals as are prescribed in regulations. Such regulations will take into account the medical severity of such conditions, the degree of incapacity, the minimum length of institutional stay generally needed for such conditions, and other pertinent factors.

Paragraph (2) of the new section 1814(h) provides that if the Secretary determines that a physician is submitting with some frequency erroneous certifications of conditions prescribed in regulations or inappropriate plans of treatment, the provisions of paragraph (1) of the section will not, after the date of such determination, apply to patients for whom such physician submits the certifications or plans of treatment.

Paragraph (1) of the new section 1814(i) provides that where (A) a patient's physician submits the certification and plan of treatment for post-hospital home health services (as required by subparagraph (D) of section 1814(a)(2) of the Act) prior to the first post-hospital home health visit by the home health agency, (B) the certification describes a medical condition of the patient which is designated in regulations, and (C) there is compliance with additional requirements and procedures prescribed in regulations, the individual will be presumed to require, for purposes of payment to the home health agency subject to the limitations of section 1812 of the Act), the care described in subparagraph (D) of section 1814(a)(2) of the Act, but only for such limited numbers of visits with respect to such conditions of individuals as are prescribed in regulations. Such regulations will take into account the medical severity of such conditions, ***5301** the degree of incapacity, the minimum period of home confinement generally needed for such conditions, and other pertinent factors.

Paragraph (2) of the new section 1814(i) provides that if the Secretary determines that a physician is submitting with some frequency erroneous certifications of conditions prescribed in regulations or inappropriate plans of treatment, the provisions of paragraph (a) of the section will not, after the date of such determination, apply to patients for whom such physician submits certifications or plans of treatment.

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Section 228(b) of the bill provides that the amendments made by section 228(a) are to be effective with respect to admissions to extended care facilities and home health plans initiated on or after January 1, 1972.

SECTION 229. AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

Section 229(a) of the bill amends section 1862 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (d) which provides that no payment may be made under either part A or B of title XVIII for items or services furnished by a person whom the Secretary determines (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under the medicare program; (2) has submitted or caused to be submitted bills or requests for payment containing charges (or costs) which the Secretary, with the concurrence of the program review team (discussed below), finds to be substantially in excess of such person's customary charges (or costs) unless there is good cause for such charges (or costs); or (3) has furnished services or supplies which the Secretary, with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality. The determinations of the Secretary pursuant to these provisions are to be effective after there has been given such reasonable notice to the public and the person involved as may be specified in regulations. The stoppage of payment is to be effective with respect to services furnished on or after the effective date of the determination (except in the case of a hospital, extended care facility, and home health agency, for which the determination would be effective in the manner provided for terminations of agreements under section 1866(b)(3) and (4) of the Act) and will continue until the Secretary finds that the abuses which led to the decision have ceased and there is reasonable assurance that they will not recur. Any person furnishing services who is dissatisfied with the Secretary's decision is entitled to a hearing by the Secretary and to judicial review of the Secretary's decision.

The new section 1862(d) also provides for the establishment by the Secretary, in each State, of one or more program review teams. In appointing these teams, the Secretary will consult with State and local professional societies, carriers and intermediaries, and consumer representatives. The duties of the teams will include (1) the review of statistical data on program utilization furnished by the Secretary; (2) the submission of periodic reports to the Secretary concerning this ***5302** review together with any recommendations they may have concerning it; (3) the review of particular cases where there is a likelihood of abuse; and (4) the submission to the Secretary of periodic reports concerning the review of such cases, together with their analyses and recommendations.

Section 229(b) of the bill amends section 1866(b)(2) of the Act to provide that the Secretary may terminate an agreement with a provider of services under the medicare program if he determines that the provider (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under that program; (2) has submitted or caused to be submitted requests for payment for services which are substantially in excess of the costs incurred in rendering such services; or (3) has furnished services or supplies which the Secretary with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality.

Section 229(c) of the bill amends section 1903(i) of the Act (as added by section 224(c) of the bill) to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished after June 30, 1971, under a State plan for medical assistance which are (1) in excess of the reasonable charge as determined under the fourth and fifth sentences of section 1842(b)(3) of the Act (as added by the bill), or (2) precluded from payment under title XVIII because of a determination of the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

Section 229(d) of the bill amends section 506(f) of the Act (as added by section 224(d) of the bill) to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished after June 30, 1971, under a State plan for maternal and child health services and services for crippled children which are (1) in excess of the reasonable charge as determined under the fourth and fifth sentences of section 1842(b)(3) of the Act (as added by the bill), or (2) precluded from payment under title XVIII because of a determination by the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

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SECTION 230. ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

Section 230 of the bill repeals section 1903(e) of the Social Security Act (and section 2(b) of Public Law 91-56) so as to remove the president requirement that each State make 'a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1977, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards'.

***5303** SECTION 231. DEDUCTIONS IN CARE AND SERVICES UNDER MEDICAID

Section 231 of the bill amends section 1902(d) of the Social Security Act (which requires that whenever a State desires a modification of its State plan so as to reduce the scope or extent of care and services or to terminate any of such care and services, it must make certain showings to the Secretary including a showing that such modification will not result in a reduction of fiscal efforts) to restrict its application to those services which are required under the plan by section 1902(a)(13) of the Act.

SECTION 232. DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND UNDER MATERNAL AND CHILD HEALTH PROGRAM

Section 232(a) of the bill amends section 1902(a)(13)(D) of the Social Security Act to authorize States to develop their own methods and standards for determining the reasonable cost of inpatient hospital care for medicaid eligibles, subject to the condition that reimbursement by States may in no case exceed the amount which would be determined to be the reasonable cost of such inpatient services under title XVIII of the Act.

Section 232(b) of the bill amends section 505(a)(6) of the Act to give States the same authority (to develop their own methods and standards for determining the reasonable cost of inpatient hospital care, subject to the specific conditions) under their maternal and child health plans.

Section 232(c) of the bill provides that these amendments will be effective July 1, 1972 (or earlier if the State plan so provides).

SECTION 233. AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

Section 233(a) of the bill amends section 1814(b) of the Social Security Act to provide that payments to nonpublic providers of services under the hospital insurance program will, subject to the applicable deductible and coinsurance provisions, be the lesser of the reasonable cost of the services as determined under section 1861(v) of the Act or the customary charges for the services. If the services are furnished free or at only nominal charge by a public provider of services, such payments will be determined on the basis of those items (specified in regulations) included in the determination of the reasonable cost which the Secretary finds will provide fair compensation for the services.

Section 233(b) of the bill amends section 1833(a)(2) of the Act to provide that payments under the medical insurance program to nonpublic providers of services will be 80 percent of the lesser of the reasonable cost of the services as determined under section 1861(v) of the Act or the customary charges for the services. Public providers which furnish services free or at nominal charge will be reimbursed at 80 percent of reasonable cost as determined under section 1814(b)(2) of the Act.

***5304** Section 233(c) of the bill amends section 1903(i) of the Act (as otherwise amended by the bill) to provide a similar basis for payments to States under their plans established and approved under title XIX of the Act.

Sections 233(d) and 233(e) of the bill amend section 506(f) and section 509(a) of the Act (as otherwise amended by the bill)

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to provide a similar basis for payments to States for items and services reimbursable under title V of the Act.

Section 233(f) of the bill provides that the amendments made by section 233(a) and (b) will apply to services furnished by hospitals, extended care facilities and home health agencies in accounting periods beginning after June 30, 1971, and that the amendments made by section 233(c), (d) and (e) will apply to services furnished by hospitals in accounting periods beginning after June 30, 1971.

SECTION 234. INSTITUTIONAL PLANNING UNDER MEDICARE

Section 234(a) of the bill amends section 1861(e) of the Social Security Act to require an institution to have in effect an overall plan and budget in order to qualify as a hospital under the medicare program.

Section 234(b) of the bill amends section 1861(f)(2) of the Act to impose a similar requirement with respect to psychiatric hospitals.

Section 234(c) of the bill amends section 1861(g)(2) of the Act to impose a similar requirement with respect to tuberculosis hospitals.

Section 234(d) of the bill amends section 1861(j) of the Act to impose a similar requirement with respect to extended care facilities.

Section 234(e) of the bill amends section 1861(o) of the Act to impose a similar requirement with respect to home health agencies.

Section 234(f) of the bill further amends section 1861 of the Act by adding a new subsection (z), when defines an overall plan and budget as one that provides for a detailed annual operating budget, and provides for a capital expenditure plan for at least a 3-year period which includes all anticipated capital expenditures in excess of $100,000, is reviewed and updated annually, and is prepared by a committee consisting of representatives of the administrative staff, the medical staff, and the governing body of the institution involved. The budget need not have an item-by-item identification of each type of anticipated expenditure or income.

Section 234(g) of the bill amends sections 1814(a)(2)(C), 1814(a)(2)(D), and 1863 of the Act to make conforming changes.

Section 234(h) of the bill amends section 1865 of the Act to provide that if the Joint Commission on Accreditation of Hospitals requires hospitals to have institutional plans as defined in the new section 1861(z) as a condition of accreditation, all hospitals accredited by the Commission may be considered as satisfying the new section 1861(e)(8).

Section 234(i) of the bill provides that these amendments will apply with respect to any provider of services for its fiscal years beginning after the fifth month following the month in which the bill is enacted.

***5305** SECTION 235. PAYMENTS TO STATES UNDER MEDICAID FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Section 235(a) of the bill amends section 1903(a) of the Social Security Act by adding a new paragraph (3).

The new section 1903(a)(3)(A) authorizes 90-percent Federal matching to enable States to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary to provide efficient and economical administration of their medicaid plans and to be compatible with claims processing and retrieval systems utilized in the administration of title XVIII of the Act, including matching of the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and that of any other State approved under title XIX of the Act. It also authorizes 90-percent Federal matching during the fiscal years 1972 and 1973, up to a total (for all States) of $150,000 in either such year, of expenditures for the design, development, or installation of cost determination systems for State-owned general hospitals.

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The new section 1903(a)(3)(B) authorizes 75-percent Federal matching of administrative expenses incurred in the operation of such systems if they are approved by the Secretary and have the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers furnishing services to such recipients, the dates on which such services were furnished, and the amount of the payments made.

Section 235(b) of the bill provides that this amendment will apply to expenditures made after June 30, 1971.

SECTION 236. PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

Section 236(a) of the bill amends section 1842(b) of the Social Security Act so as to prohibit payment for services provided under the supplementary medical insurance program to anyone other than the individual to whom the services were provided or the physician or other person providing the services. However, payment may be made to the employer of the physician or other person providing the services if such physician or other person is required as a condition of his employment to turn over his fee for such services to his employer; and, where the service is provided in a hospital, clinic, or other facility, payment, may be made to the facility if there is a contractual arrangement between the physician or other person and the facility under which the facility submits the bill for such services.

Section 236(b) of the bill amends section 1902(a) of the Act so as to prohibit payment for services provided under approved State medicaid programs to anyone other than the physician, dentist, or other independent practitioner who provided the services. However, payment may be made to the employer of such physician, dentist, or other independent practitioner if he is required as a condition of his employment to turn over his fee for such services to the employer; and, where the care or service is provided in a hospital, clinic or other facility, payment may be made to the facility if there is a contractual arrangement between the practitioner and the facility under which the facility submits the bill for such services.

***5306** Section 236(c) of the bill provides that the amendment made by section 236(a) will apply with respect to bills submitted and requests for payment made after the date of enactment of the bill, and that the amendment made by section 236(b) will be effective July 1, 1972, or earlier if the State plan so provides.

SECTION 237. UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND UNDER MATERNAL AND CHILD HEALTH PROGRAM

Section 237(a)(1) of the bill amends the new section 1903(i) of the Social Security Act to require as a condition of payment under the medicaid program that hospitals and skilled nursing homes participating in such program have their medicaid cases reviewed by the same utilization review committee which already reviews their medicare cases or, if such a committee does not exist, by a committee which meets the requirements imposed by section 1861(k) of the Act for purposes of the medicare program.

Section 237(a)(2) of the bill amends section 1902(a)(30) of the Act to make a conforming change.

Section 237(b) of the bill amends section 506(f) of the Act to impose with respect to services provided by hospitals and skilled nursing homes under the maternal and child health program (title V of the Act) the same utilization review requirement as is imposed with respect to services under the medicaid program under the amendment made by section 237(a)(1).

Section 237(c) of the bill provides that the amendments made by section 235(a)(1) and (b) will apply to services furnished after June 30, 1972, and that the amendment made by section 235(a)(2) will be effective July 1, 1972.

SECTION 238. NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE

Section 238(a) of the bill amends section 1814(a)(7) of the Social Security Act to include among the cases where medicare

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payments are to be terminated for medically unnecessary services those cases where the services involved are found to be medically unnecessary by a utilization review committee or group in the course of its sample or other review of admissions to a hospital or extended care facility.

Section 238(b) of the bill provides that this amendment will be effective with respect to services furnished after the second month following the month in which the bill is enacted.

SECTION 239. USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND UNDER MATERNAL AND CHILD HEALTH PROGRAM

Section 239(a) of the bill amends section 1902(a)(9) of the Social Security Act to require State medicaid plans to provide that the State health agency or other appropriate State medical agency (whichever is utilized by the Secretary for purposes of section 1864(a) of the Act) will have responsibility for establishing and maintaining health standards for institutions in which medicaid recipients may receive care or services (with the State authority or authorities presently referred ***5307** to in sec. 1902(a)(9) retaining responsibility for establishing and maintaining standards other than those relating to health for such institutions).

Section 239(b) of the bill amends section 1902(a) of the Act by adding (in a new par. (32)) a new plan requirement under which the State health agency or other appropriate State medical agency is given responsibility for establishing a plan for the review by professional health personnel of the quality and appropriateness of care and services furnished to medicaid recipients in order to provide guidance to the State medicaid agency and (in most cases) is given responsibility for determining whether institutions and agencies meet the applicable requirements for participation in the medicaid program.

Section 239(c) of the bill amends section 505(a) of the Act by adding (in a new par. (15)) substantially the same new plan requirement for maternal and child health purposes.

Section 239(d) of the bill provides that these amendments will be effective July 1, 1972.

SECTION 240. RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH CARE PROGRAMS

Section 240 of the bill amends section 1902(a)(23) of the Social Security Act to provide that a State plan will not be deemed out of compliance with section 1902(a)(23) (freedom of choice requirement), section 1902(a)(1) (statewideness requirement), or section 1902(a)(10) (amount, duration and scope requirement) solely by reason of the fact that the State (or a political subdivision thereof) has entered into a contract with an organization which agrees to provide care and services in excess of those offered under the State plan to eligible individuals who reside in the geographic area served by the organization, and who elect to obtain such care and services from such organization.

SECTION 241. PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

Section 241 of the bill amends title XI of the Social Security Act by adding at the end a new section 1123.

Subsection (a) of the new section 1123 requires the Secretary (in consultation with appropriate professional organizations and State health and licensure agencies) to develop and conduct a program to determine the proficiency of those persons who do not meet the educational, professional membership, or other criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians and technologists, X-ray technicians, psychiatric technicians, or other health care technicians. This program will include (but not be limited to) the use of procedures for the formal testing of the proficiency of such personnel. No person who otherwise meets the proficiency requirements may be denied a satisfactory proficiency rating solely for failure to meet formal educational or professional membership requirements.

Subsection (b) of the new section 1123 provides that no person or provider using the health care services of an individual determined qualified under section 1123(a) may be denied payment under title XVIII or under State plans approved under title XIX on the grounds that such individual is not qualified to perform these services.

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***5308** SECTION 242. PENALTIES FOR FRAUDULENT ACTS AND FALSE REPORTING UNDER MEDICARE AND MEDICAID

Section 242(a) of the bill eliminates the incorporation of section 208 of the Social Security Act, by reference in title XVIII of the Act. (Section 208 includes penalties for the making of a false statement or representation of a material fact under title II of the Act.)

Section 242(b) of the bill adds to the Act a new section 1877.

Under the new section 1877(a), whoever knowingly and willfully makes or causes to be made any false statement of material fact in any application for Medicare benefits or payments or use in determining rights to such benefits or payments; fraudulently conceals or fails to disclose an event affecting initial or continued right to such benefits or payments; or, having made application for and received medicare benefits or payments on behalf of another, knowingly and willfully converts either all or part of them to a use other than for the use or benefit for which they are intended, is guilty of a misdemeanor and upon conviction subject to a fine of not more than $10,000 or imprisonment for not more than one year, or both.

Under the new section 1877(b), any provider of services, supplier, physician, or other person who furnishes items or services for which Medicare payment of or may be made and who solicits, offers, or receives any (a) kickback or bribe in connection with the furnishing of such items or services or with the making or receipt of such payment, or (2) rebate of any fee or charge for referring an individual to another person for the furnishing of such items or services, is guilty of a misdemeanor and subject to a fine of not more than $10,000 or imprisonment for not more than one year, or both.

Under the new section 1877(c), whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, a false statement or representation of material fact with respect to the condition or operation of any institution or facility in order to qualify as a provider of services under title XVIII of the Act is guilty of a misdemeanor and subject to a fine of not more than $2,000 or imprisonment for not more than 6 months, or both.

Section 242(c) of the bill adds to the Act a new section 1909, which includes a similar description of fraudulent acts and false reporting and the same penalty provisions as the new section 1877 described above, except that the new section 1909 applies to items or services furnished an individual for which payment is or may be made, in whole or in part, out of federal funds under a State plan approved under title XIX of the Act.

Section 242(d) of the bill provides that these amendments are not applicable to any acts, statements, or representations made or committed prior to the enactment of the bill.

SECTION 243. PROVIDER REIMBURSEMENT REVIEW BOARD

Section 243 of the bill amends title XVIII of the Social Security Act by adding to the end a new section 1878 establishing a Provider Reimbursement Review Board.

Subsection (a) of the new section 1878 provides that any provider of services that filed a required cost report on a timely basis (in accordance ***5309** with regulations) may have a hearing before a Provider Reimbursement Review Board with respect to that cost report if (1) the provider is dissatisfied with the final determination of its fiscal intermediary as to the amount of total program reimbursement due the provider for items and services furnished under title XVIII of the Act during the period covered by the report, (2) the amount in controversy is at least $10,000, and (3) the provider files a request for the hearing within 180 days after notice of the intermediary's final determination.

Subsection (b) of the new section 1878 provides that during such hearing the provider of services may be represented by counsel, examine and cross-examine witnesses, and introduce evidence (including evidence which would be inadmissible under rules applicable to court procedures).

Subsection (c) of the new section 1878 provides that the Board's decision must be supported by substantial evidence in the

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record as a whole, including evidence considered by the intermediary and other evidence secured by the Board. The Board may affirm, modify, or reverse the fiscal intermediary's determination, including revisions which are adverse to the provider and revisions involving matters not considered by the intermediary.

Subsection (d) of the new section 1878 authorizes the Board to establish all necessary rules and procedures, to administer oaths and affirmations, and to issue subpoenas under the same conditions applied to the Secretary in issuing subpoenas under title II of the Act.

Subsection (e) of the new section 1878 provides that the Board's decision shall be final unless reversed or modified adversely to the provider by the Secretary on his own motion and within 60 days after the provider receives notification of the Board's decision. Where the Secretary reversed or modifies the Board's decision, the provider may obtain judicial review by civil action brought in the United States district court for the district where it is located or in the District Court for the District of Columbia under the administrative procedure provisions of title 5, United States Code, if such action is filed within 60 days of receipt of notice of the Secretary's determination.

Subsection (f) of the new section 1878 provides that no determination by a fiscal intermediary regarding exclusion from coverage (under section 1862 of the Act) of items and services furnished an individual may be reviewed by the Board or any court under the new section.

Subsection (g) of the new section 1878 provides that the Board is to be composed of five members knowledgeable in the field of cost reimbursement, including at least one certified public accountant and two members representative of providers of services, appointed for 3-year terms, except that initial appointments may be for such lesser terms as necessary to permit staggered terms of office. Appointments may be made without regard to the provisions of title 5 of the United States Code governing appointments in the competitive services and rates of compensation will be fixed by the Secretary not to exceed the rate for grade GS-18.

Subsection (h) of the new section 1878 authorizes the Board to secure necessary technical services and directs the Secretary to provide necessary secretarial, clerical and other assistance.

Section 243(b) of the bill amends section 1816(a) of the Act to make appropriate reference to the appeal procedure (established by ***5310** section 1878) in the provision governing contracts with fiscal intermediaries.

Section 243(c) of the bill provides that these amendments will apply with respect to provider cost reports under title XVIII of the Act for accounting periods beginning after June 30, 1971.

PART C-MISCELLANEOUS AND TECHNICAL PROVISIONS

SECTION 251. PHYSICAL THERAPY SERVICES AND OTHER THERAPY SERVICES UNDER MEDICARE

Section 251(a)(1) of the bill amends section 1861(p) of the Social Security Act to include as 'outpatient physical therapy services' the physical therapy services furnished an individual by a physical therapist in his office or in the individual's home where the services are furnished other than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency. The furnishing of such services must meet such conditions relating to health and safety as the Secretary may find necessary; and the physical therapist must meet licensing and other standards prescribed by the Secretary in regulations.

Section 251(a)(2) of the bill amends section 1833 of the Act by adding a new subsection to provide that no more than $100 in any calendar year may be considered as incurred expenses for purposes of payment for physical therapy services described in section 251(a)(1) of the bill.

Section 251(a)(3) of the bill amends section 1833(a)(2) of the Act to limit reimbursement for such services described in section 251(a)(1) of the bill to reasonable charges for such services.

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Section 251(a)(4) of the bill amends section 1832(a)(2)(C) of the Act to permit payment for the benefit provided by section 351(a)(1) of the bill directly to the individual who received the services, or, on his behalf and upon his assignment, to the physical therapist who furnished the services.

Section 251(b) of the bill amends section 1861(p) of the Act to include as ‘outpatient physical therapy services‘ the physical therapy services furnished by a hospital or an extended care facility to an inpatient of such institution provided such services meet the requirements of section 1861(p) applicable to individuals receiving such services as outpatients from a provider of services, clinic, rehabilitation agency, or public health agency, or by others under arrangements with such a provider or organization.

Section 251(c) of the bill amends section 1861(v) of the Act to limit payment for physical, occupational, speech, or other therapy services, or services of other health-related personnel (other than physicians) furnished by a provider of services or by a clinic, rehabilitation agency, or public health agency, or by others under arrangements with such a provider, agency, or organization. Such payment would be limited to the amount of salary which reasonably would have been paid if the services had been performed by an employee of such a provider or organization (rather than under an arrangement with such a provider or organization to provide such services) plus the cost of such other expenses incurred by the person performing such services on other than an employee basis as the Secretary may determine in regulations to be appropriate.

***5311** Section 251(d) of the bill provides that the amendments made by sections 251(a), (b), and (c) of the bill will apply with respect to services furnished on or after January 1, 1972, with respect to services furnished on or after the date of enactment, and with respect to accounting periods beginning on or after January 1, 1972, respectively.

SECTION 252. COVERAGE OF SUPPLIES RELATED TO COLOSTOMIES

Section 252(a) of the bill amends section 1861(s)(8) of The social Security Act to include colostomy bags and supplies directly related to colostomy care as covered prosthetic devices under the supplementary medical insurance program.

Section 252(b) of the bill provides that this amendment will apply with respect to items furnished on or after the date of enactment of the bill.

SECTION 253. COVERAGE OF PTOSIS BARS

Section 253(a) of the bill amends section 1861(s)(9) of the Social Security Act to cover ptosis bars under the supplementary medical insurance program.

Section 253(b) of the bill provides that this amendment will apply with respect to items furnished on or after the date of enactment of the bill.

SECTION 254. INCLUSION UNDER MEDICAID OF CARE IN INTERMEDIATE CARE FACILITIES

Section 254(a)(1) of the bill amends section 1905(a) of the Social Security Act by inserting a new paragraph (16) which authorizes Federal matching under title XIX of the Act for intermediate care facility services (other than such services in an institution for tuberculosis or mental disease) for individuals who are determined in accordance with section 1902(a)(33)(A) (discussed below) to be in need of such services.

Section 254(a)(2) of the bill amends section 1905 of the Act by adding a new subsection (c) which defines ‘intermediate care facility‘ as an institution or distinct part thereof which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled home is designed to provide, but who because of their mental or physical condition require care and services (beyond the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care and (3) meets such standards of safety and sanitation as are applicable to nursing homes under State law. The term ‘intermediate care facility‘ also includes a

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Christian Science Sanatorium, but only with respect to institutional services deemed appropriate by the State. For services furnished to individuals under age 65, the term does not include (except as prescribed in the new section 1905(d)) any public institution for mental diseases or mental defects.

Section 254(a)(2) of the bill further amends section 1905 of the Act by adding a new subsection (d) which provides that the term 'intermediate ***5312** care facility services' may include services in a public institution (of distinct part thereof) for the mentally retarded or persons with related conditions if (1) the primary purpose of such institution (or distinct part thereof) is to provide for mentally retarded individuals health care rehabilitative services which meet such standards as may be prescribed by the Secretary, (2) the mentally retarded individual with respect to whom a request for payment if made under the approved State plan is receiving active treatment under such a program, and (3) the State or political subdivision responsible for the operation of such institution has agreed that the non-federal expenditures with respect to patients in such institution (or distinct part thereof) will not be reduced because of payments made under title XIX of the Act.

Section 254(b) of the bill amends section 1902(a) of the Social Security Act by adding a new paragraph (33) which provides in the case of intermediate care facilities for (A) a regular program of independent professional review (including medical evaluation of each patient's need for such care) and a written plan of the service prior to admission or authorization of benefits which provides more than a minimum level of health care services as determined by regulations, (B) periodic inspection in all facilities (if the State plan includes ICF care) by one or more independent professional review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided medicaid eligibles, (ii) the adequacy of services available in particular facilities to meet current health needs and promote maximum physical well-being of patients (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their needs through alternative institutional or noninstitutional services, and (C) for the making of reports and recommendations by such teams to the State agency administering or supervising the administration of the State plan.

Section 254(c) of the bill repeals section 1121 of the Act (the existing provisions relating to intermediate care facilities).

Section 254(d) of the bill provides that these amendments will be effective January 1, 1972.

SECTION 255. COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

Section 255(a) of the bill amends section 1902(a) of the Social Security Act by adding in a new paragraph (34) a requirement under which State medicaid plans must provide for payments of medical assistance to eligible individuals where care or services included in the plan were furnished in or after the third month prior to the month of application and such individuals were otherwise eligible when the care or services were received.

Section 255(b) of the bill provides that this amendment will be effective July 1, 1971.

SECTION 256. HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE

Section 256(a) of the bill amends section 1814(a)(2) of the Social Security Act by adding a new subparagraph (E) which provides that, ***5313** in order to receive payment for inpatient hospital services in connection with a dental procedure, a physician must certify that the patient suffers from impairments which are of such severity that the requires hospitalization.

Section 256(b) of the bill amends section 1861(r) of the Act to provide that a doctor of dentistry or of dental or oral surgery may make the certification described in the new section 1814(a)(2)(E).

Section 256(c) of the bill amends section 1862(a)(12) of the Act to make it clear that payment may be made under part A for inpatient hospital services in connection with dental procedures when the patient suffers from severe impairments which require that he be hospitalized.

Section 256(d) of the bill provides that these amendments will be effective with respect to admissions occurring after the second month following the month of enactment.

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SECTION 257. EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

Section 257(a) of the bill amends section 1838(b) of the Social Security Act (which presently provides that termination of coverage under the supplementary medical insurance program for nonpayment of premiums shall be deferred for a grace period not in excess of 90 days during which overdue premiums may be paid and coverage continued) to authorize the extension of the grace period for an additional 90 days where the Secretary determines that there was a good cause for failure to pay the overdue premiums within the initial 90-day period.

Section 257(b) of the bill provides that this amendment will apply with respect to nonpayment of premiums becoming due and payable on or after the date of enactment of the bill. For purposes of the amendment any premium which became due and payable within the 90-day period immediately preceding the date of enactment is considered as becoming due and payable as of such date.

SECTION 258. EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

Section 258(a) of the bill amends section 1842(b)(3) of the Social Security Act to provide that a bill submitted or a request for payment made after the close of the calendar year following the year in which the related service was furnished may be honored notwithstanding the lapse of time if the delay in submitting the bill or in requesting the payment is due to error or misrepresentation of the Government or one of its agents and if the bill is submitted or the request for payment is made as soon as possible after the fact of such error or misrepresentation is established.

Section 258(b) of the bill provides that this amendment will apply with respect to bills submitted and requests for payment made after March 1968.

***5314** SECTION 259. WAIVER OF ENROLLMENT PERIOD REQUIREMENT WHERE INDIVIDUAL'S RIGHTS WERE PREJUDICED BY ADMINISTRATIVE ERROR OR INACTION

Section 259(a) of the bill amends section 1837 of the Social Security Act by adding a new subsection (h), providing that where the Secretary finds that an individual's enrollment or nonenrollment in the supplementary medical insurance program is unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a departmental officer, employee, or agent, the Secretary may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums).

Section 259(b) of the bill provides that this amendment will be effective as of July 1, 1966.

SECTION 260. ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN THREE YEARS AFTER FIRST OPPORTUNITY

Section 260 of the bill amends section 1837(b) of the Social Security Act to permit eligible individuals to enroll or reenroll in the supplementary medical insurance program during any prescribed general enrollment period by eliminating the requirement that an individual must enroll (or reenroll after termination of a previous enrollment) within 3 years following the close of his initial enrollment period (or following the effective date of such termination). The restriction that no individual may enroll in the supplementary medical insurance program more than twice is retained.

SECTION 261. WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE

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Section 261(a) of the bill amends section 1870(c) of the Social Security Act (which presently provides that with respect to an overpayment there will be no adjustment as required under section 1870(b) of the Act (or recovery) in any case in which the individual to whom the incorrect payment was made is without fault and where such adjustment (or recovery) would defeat the purpose of Title II of the Act or would be against equity and good conscience) to make its provisions applicable to any person (such as a survivor of the individual to whom the incorrect payment was made) who is without fault.

Section 261(b) of the bill provides that this amendment will apply with respect to waiver actions considered after the date of enactment of the bill.

SECTION 262. REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 262(a) of the bill amends section 1842(b)(3)(C) of the Social Security Act (which presently provides that enrollees in the ***5315** supplementary medical insurance program will be granted fair hearings by the carrier in cases where requests for payment are denied or are not acted upon with reasonable promptness or when the amount of payment is in controversy) to provide that a minimum amount of $100 must be at issue before such a hearing will be granted.

Section 262(b) of the bill provides that this amendment will apply with respect to hearings requested after the date of enactment of the bill.

SECTION 263. COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

Sections 263(a), (b), (c), (d)(1), (d)(2), (d)(3), and (d)(4) of the bill amend sections 1840 and 1841 of the Social Security Act to provide that a railroad retirement beneficiary's monthly supplementary medical insurance premiums will be deducted from his railroad retirement pension regardless of any entitlement he may have to monthly benefits under title II of the Act.

Section 263(d)(5) of the bill amends section 1842 of the Act by adding a new subsection (g) which gives the Railroad Retirement Board authority to contract with a carrier for part B benefits for its beneficiaries.

Section 263(e) of the bill amends section 1841 of the Act by adding a new subsection (i) providing that the Managing Trustee of the Supplementary Medical Insurance Trust Fund is to reimburse the Railroad Retirement Board from the Trust Fund in such amounts as the Secretary of Health, Education, and Welfare determines to be equal to the costs incurred by the Board in making the premium deductions and for carrier operations.

Section 263(f) of the bill provides that these amendments will apply with respect to premiums becoming due and payable after the fourth month following the month of enactment of the bill.

SECTION 264. PROSTHETIC LENSES FURNISHED BY OPTOMETRISTS UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 264(a) of the bill amends section 1861(r) of the Social Security Act to include a licensed doctor of optometry, legally authorized to practice optometry by the State in which he performs such function, within the definition of the term 'physician,' but only with respect to establishing the necessity for prosthetic lenses.

Section 264(b) of the bill provides that this amendment will apply only with respect to services performed on or after the date of enactment of the bill.

SECTION 265. PROVISION OF MEDICAL SOCIAL SERVICES NOT MANDATORY FOR EXTENDED CARE FACILITIES

Section 265 of the bill amends section 1861(j)(11) of the Social Security Act (as redesignated by section 234(d) of the bill) to

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provide that the Secretary may not require any institution to furnish medical social services in order to participate as an extended care facility in the Medicare program.

***5316** SECTION 266. REFUND OF EXCESS PREMIUMS UNDER MEDICARE

Section 266 of the bill amends section 1870 of the Social Security Act to provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums paid by a deceased enrollee in the same manner as unpaid medical insurance benefits are treated. (That is, in cases where there is no legal representatives of the enrollee's estate, these premium amounts would be added to benefits payable on the same Medicare claims number, or to those relatives who would (except for age and dependency requirements) be eligible on the same number.)

SECTION 267. WAIVER OF REQUIREMENT OF REGISTERED PROFESSIONAL NURSES IN SKILLED NURSING HOMES IN RURAL AREAS UNDER MEDICARE

Section 267 of the bill amends section 1902(a)(28)(B) of the Social Security Act (which requires skilled nursing homes to have an organized nursing service under the direction of a full-time professional registered nurse) to authorize a State agency with the approval of the Secretary to waive this requirement for any one-year period (or less) ending no later than December 31, 1975, when immediately preceeding such period he finds that (i) the nursing home is located in a rural area and the supply of skilled nursing home services in such area is not sufficient to meet the needs of individuals residing therein, (ii) the failure of the nursing home to qualify as a skilled nursing home would seriously reduce the availability of such services to beneficiaries in such area, (iii) the nursing home has made and continues to make a good faith effort to comply with the requirement, but such compliance is impeded by the lack of qualified nursing personnel in such area, and (iv) the requirement of the section were met for a regular daytime shift.

SECTION 268. EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID

Section 268(a) of the bill amends section 1902(a) of the Social Security Act to exclude Christian Science sanatoriums from the terms 'skilled nursing home' and 'nursing home' for specified medicaid purposes and thereby to exempt them from the requirements established for skilled nursing homes which relates to medical practices and activities such as maintaining an organized nursing service under the direction of a registered nurse, maintaining detailed medical records, having diagnostic and other service arrangements with general hospitals, and having a skilled nursing home administrator licensed by the State. States are relieved of the requirement that they provide regular medical review and periodic inspections of the care provided in Christian Science sanitariums.

Section 267(b) of the bill amends section 1908(g)(1) of the Act, relating to State programs for licensing nursing home administrators) to provide that the term 'nursing home' contained therein does not include Christian Science Sanatoriums.

Section 267(c) of the bill provides that these amendments will be effective upon the enactment of the bill.

***5317** SECTION 269. REQUIREMENTS FOR NURSING HOME ADMINISTRATORS

Section 269 of the bill amends section 1908(d) of the Social Security Act to provide that no State will be considered to have failed to comply with the requirement (in section 1902(a)(29) of the Act) that it have a program for licensing nursing home administrators because the State agency or board has granted a waiver of any of its standards in the case of an individual who has served as a nursing home administrator during all of a specified 3-calendar year period.

SECTION 270. TERMINATION OF NATIONAL ADVISORY COUNCIL ON NURSING HOME ADMINISTRATION

Section 270 of the bill amends section 1908(f)(5) of the Social Security Act by changing the termination date of the National Advisory Council on Nursing Home Administration from December 31, 1971, to 30 days after the date of the enactment of

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the bill.

SECTION 271. INCREASE IN Limitation ON PAYMENTS TO PUERTO RICO FOR MEDICAL ASSISTANCE

Section 217(a) of the bill amends section 1108(c)(1) of the Social Security Act to increase from $20 million to $30 million the Federal ceiling on title XIX payments to Puerto Rico.

Section 270(b) provides that this amendment will apply with respect to fiscal years beginning after June 30, 1971.

SECTION 272. EXTENSION OF TITLE V TO AMERICAN SAMOA AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS

Section 272(a) of the bill amends section 1101(a)(1) of the Social Security Act to provide that the term 'State', when used in title V of the Act (relating to State programs of maternal and child health and crippled children's services), is to include American Samoa and the Trust Territory of the Pacific Islands.

Section 272(b) of the bill amends section 1108(d) of the Act to permit the Secretary to make initial allotments under title V to American Samoa and the Trust Territory which are smaller than those otherwise provided for other States.

Section 272(c) of the bill provides that these amendments will apply to fiscal years beginning after June 30, 1971.

SECTION 273. STUDY OF CHIROPRACTIC COVERAGE

Section 273 of the bill directs the Secretary of Health, Education, and Welfare, under the authority conferred by section 1110 of the Social Security Act, to conduct a study of the coverage of services performed by chiropractors under Medicaid (title XIX of the Act) in order to determine whether, and to what extent, such services should be covered under part B of Medicare (title XVIII of the Act). The Secretary is to give particular attention to the limitations which should be placed upon the coverage of and payment for chiropractic services. The study is to include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled ***5318** conditions the information necessary to achieve the objectives of the study. The Secretary is required to report the results of the study to the Congress within 2 years after the date of the bill's enactment, and to include in the report his findings and recommendations based on the study and other relevant information concerning experience with the coverage of chiropractors by public and private plans.

SECTION 274. MISCELLANEOUS TECHNICAL AND CLERICAL AMENDMENTS

Section 274 of the bill corrects clerical deficiencies in sections 1902(a)(26)(A) and 1908(d) of the Social Security Act.

TITLE III-ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

SECTION 301. ESTABLISHMENT OF PROGRAM

Section 301 of the bill amends the Social Security Act by adding at the end a new title XX, establishing a Federal program of assistance for the aged, blind, and disabled.

TITLE XX-ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

SECTION 2001. PURPOSE; APPROPRIATIONS

Section 2001 authorizes the appropriation of funds to meet the costs of the new national program of assistance to needy aged,

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blind, or disabled individuals.

SECTION 2002. BASIC ELIGIBILITY FOR BENEFITS

Section 202 provides for payment of benefits to eligible aged, blind, or disabled individuals by the Secretary of Health, Education, and Welfare.

PART A-DETERMINATION OF BENEFITS

SECTION 2011. ELIGIBILITY FOR AND AMOUNT OF BENEFITS

Definition of eligible individual

Section 2011(a) defines an eligible individual as--

(1) an aged, blind, or disabled individual without an eligible spouse whose nonexcluded income is at a rate of not more than $790 for the second half of 1972 and for the first half of 1973 (i.e., $1,560 for the fiscal year 1973), $840 for the second half of 1973 and for the first half of 1974 (i.e., $1,680 for the fiscal year 1974), $900 for the second half of 1974, or $1,800 for 1975 or any later year, and whose nonexcluded resources are not more than $1,500; or

(2) an individual with an eligible spouse whose nonexcluded income (combined with that of his spouse) is at a rate of not more than $1,170 for the second half of 1972 and for the first half of 1973 (i.e., $2,340 for the fiscal year 1973), $1,200 for the second half of 1973, or $2,400 for 1974 or any later year, ***5319** and whose nonexcluded resources (combined with those of his spouse) are not more than $1,500.

Amount of benefits

Section 2011(b) provides for benefits for an eligible individual without an eligible spouse at a rate of $780 for the second half of 1972 and for the first half of 1973 (i.e., $1,560 for the fiscal year 1973), $840 for the second half of 1973 and for the first half of 1974 (i.e., $1,680 for the fiscal year 1974), $900 for the second half of 1974, and $1,800 for 1975 or any later year, reduced by the amount of his nonexcluded income; and provides for benefits for an individual with an eligible spouse at a rate of $1,170 for the second half of 1972 and for the first half of 1973 (i.e., $2,340 for the fiscal year 1973), $1,200 for the second half of 1973, and $2,400 for 1974 or any later year, reduced by the amount of his nonexcluded income (combined with that of his spouse).

Period for determination of benefits

Section 2011(c)(1) provides that benefit eligibility and benefit amounts are to be determined for each calendar quarter and that redeterminations are to be made as provided by the Secretary, to be effective prospectively.

Section 2011(c)(2) provides that the Secretary is to prescribe when and by how much a benefit will be reduced by reason of time elapsed between the beginning of a quarter and the application date.

Section 2011(c)(3) provides that an application will be considered to have been filed on the first day of the month in which it was actually filed.

Special limits on gross income

Section 2011(d) provides that the Secretary may prescribe the circumstances under which an individual will be made

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ineligible for benefits on the basis of gross income from a trade or business.

Limitation on eligibility of certain individuals

Section 2011(e)(1)(A) provides that no person (with the exception specified in subparagraph (B) will be eligible for benefits for any month throughout which he is an inmate of a public institution.

Section 2011(e)(1)(B) provides that if an eligible individual or eligible spouse, for any full month, is in a hospital, extended care facility, nursing home, or intermediate care facility receiving Medicaid payments for services to the individual or spouse under an approved State plan, the benefit for the month (to the extent attributable to that individual or spouse) will be payable at the rate of not more than $300 per year (reduced by any nonexcluded income); if both an eligible individual and his eligible spouse are hospitalized their benefits will be payable at the maximum rate of $600 per year (so reduced.) Where only one member of an eligible couple is hospitalized, the nonhospitalized member will get benefits at the rate applicable for individuals without eligible spouses.

Section 2011(e)(2) provides that if, after being notified by the Secretary that it is likely that he is eligible for payments of the type enumerated in section 2012(a)(2)(B)-- that is, a pension, workmen's compensation payment, social security, annuity, etc.-- a person fails within 30 days to apply for and take the steps necessary to obtain such payments, he will not be considered eligible for benefits under title XX.

***5320** Section 2011(e)(3)(A) provides that if an individual's disability as determined by the Secretary is due, in whole or in part, to drug or alcohol abuse he will not be considered eligible for benefits under title XX unless he is undergoing appropriate treatment (if available) at an institution approved by the Secretary and shows he is complying with the requirements of the treatment.

Section 2011(e)(3)(B) provides that the Secretary is to monitor individuals receiving benefits who are undergoing treatment as so required, and submit to Congress annually a report showing the results thereof, in order to assure compliance with and achievement of the purposes of this paragraph.

Section 2011(e)(3)(C) defines the terms 'drug abuse' and 'alcohol abuse'.

Suspension of payments to individuals who are outside the United States

Section 2011(f) provides that no person will be eligible for assistance for any month spent wholly outside the United States. Any individual who has been outside the United States for any 30 consecutive days will be considered to be remaining outside the United States until he has been in the United States for 30 consecutive days.

Puerto Rico, the Virgin Islands, and Guam

Section 2011(g), provides a cross reference to the special provisions for determining eligibility for and amounts of benefits for Puerto Rico, and Virgin Islands, and Guam, as set forth in section 1108(e) of the Act (which is added by section 504 of the bill, discussed below).

SECTION 2012. INCOME

Meaning of income

Section 2012(a) provides that for purposes of the new title XX income means both earned and unearned income.

Earned income is defined in paragraph (1) as--

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(A) an individual's wages within the meaning of section 203(f)(5)(C) of the Act, which defines wages for purposes of the social security retirement test (generally remuneration from employment), and

(B) an individual's net earnings from self-employment as defined in section 211 of the Act, excluding that part of section 211 which deals with optional methods of computing net earnings, and including certain services performed by ministers, Christian Science practitioners, and members of religious orders, and by certain members of religious faiths who have received an exemption from coverage. Certain relatively minor items that are excluded from earned income under the basic definition in title II would be subject to determination by the Secretary of Health, Education, and Welfare as to whether they should be considered to be earned or unearned income or not income at all (as, for example, in the case of certain employer payments into health care or retirement funds).

Unearned income is defined in paragraph (2) as all income other than earned income (as defined in paragraph (1)). Specifically, unearned income includes support and maintenance, except that the benefits of any eligible individual or spouse as specified in subsections (a) ***5321** and (b) of section 2011 will be reduced by one-third if such individual or spouse is living in another person's household and receiving support from that person; any payments received as annuity, pension, retirement, or disability benefits, including veterans' or workmen's compensation, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment benefits; prizes and awards; gifts, support and alimony payments, and inheritances; and rents, interest, dividends, and royalties. The proceeds of any life insurance policy will be considered as unearned income to the extent they exceed the amount of the insured individual's burial expenses, or to the extent they exceed $1,500, if less.

Exclusions from income

Section 2012(b) provides that the following are to be excluded in determining the income of an individual (and his eligible spouse):

(1) to the extent allowed by the Secretary, the earnings of a child who is a student;

(2) income received too infrequently or irregularly to be otherwise included up to $30 per quarter of earned income and $60 per quarter of unearned income;

(3)(A) if such individual (or spouse) is blind or disabled-- (i) the first $1,020 per year (or proportionately smaller amounts for shorter periods-- $85 per month) of earned income not previously excluded, plus one-half of the remainder (ii) in the case of the blind, an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where the individual has a plan for achieving self-support approved by the Secretary, as may be necessary for its fulfillment; and

(B) if the individual (or spouse) is not blind for disabled, the first $720 per year (or proportionately smaller amounts for shorter periods-- $60 per month) of earned income not previously excluded, plus one-third of the remainder;

(4) any assistance (except veterans' pensions) which is based on need and is furnished by a State or political subdivision of a State, or by any Federal agency, or by any private religious, educational, charitable, or scientific tax-exempt organization (but this provision is subject to a significant exception; any supplementary State payment based on need which is inconsistent with the earnings incentives provision of the title XX program or which otherwise does not comply with the requirements of section 2016 would be considered to be unearned income for purposes of the basic Federal payment);

(5) those portions of any grants, scholarships, or fellowships which are for use in paying the cost of tuition and fees at an educational institution;

(6) home produce of the individual (or spouse) used for home consumption;

(7) one-third of any payment for the support of a child from an absent parent;

(8) amounts received for the foster care of a noneligible child who is living in the same home as the eligible individual and

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was placed in that home by a public or nonprofit private child-placement agency.

***5322** Section 2012(c) makes cross references to section 1007 of the **Social Security Amendments** of 1969 and section 2016(c)(1) of the new title XX, discussed below. Section 1007 requires (under the State supplementation provision) an additional income exclusion of up to $4 a month for certain railroad retirement recipients and social security beneficiaries, and section 2016()(1) permits (under such provision) an additional income exclusion of up to $7.50 a month.

SECTION 2013. RESOURCES

Exclusions from resources

Section 2013(a) provides for excluding from the resources of an eligible individual (and his eligible spouse, if any) the home, household goods, and personal effects to the extent that their value does not exceed an amount determined to be reasonable by the Secretary, along with other property which the Secretary determines by regulation to be essential to the individual's (and his spouse's) means of self-support, and for excluding the resources of a blind or disabled individual necessary for the fulfillment of a plan for achieving self-support approved by the Secretary. (Other resources would be counted in determining whether includible resources equal or exceed $1,500.)

An insurance policy of an individual (or eligible spouse) will be taken into account only to the extent of its cash surrender value, except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy will be taken into account.

Disposition of resources

Section 2013(b) directs the Secretary to provide by regulations for the manner of disposing of resources in order to qualify for benefits. Any benefits paid in a period during which resources are being disposed of, as so provided, are conditioned on such disposal and will be considered overpayments (and therefore recoverable) to the extent that they would not have been paid had the disposal occurred at the beginning of the period for which the benefits were paid.

SECTION 2014. MEANING OF TERMS

Aged, blind, or disabled individual

Section 2014(a)(1) defines the term 'aged, blind, or disabled individual' as an individual who (1) is 65 years of age or older, is blind, or is disabled, and (2) is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence.

Section 2014(a)(2) defines blindness as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees will be considered as having a central visual acuity of 20/200 or less. In any case an individual will be considered blind for purposes of title XX if he received aid as a blind person for June 1972 under a State plan approved under title X or XVI of the Act as then in effect, so long as he remains blind.

***5323** Section 2014(a)(3)(A) provides that an individual will be considered disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months, or, in the case of a child under age 18 if he suffers from any medically determinable physical or mental impairment of comparable severity. In any case, an individual will be considered disabled for purposes of tile XX if he received aid as a permanently and totally disabled person for June 1972 under a State plan approved under title XIV or XVI of the Act as then in effect, so long as he remains disabled.

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Section 2014(a)(3)(B) provides that an individual (other than a child under age 18) will be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that the is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. The term 'work which exists in the national economy' means with respect to any individual, work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

Section 2014(a)(3)(C) defines a 'physical or mental impairment' as an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

Section 2014(a)(3)(D) provides that the Secretary will prescribe by regulations the criteria for determining when an individual's services or earnings demonstrate his ability to engage in substantial gainful activity. An individual whose services or earnings meet such criteria will, except during a trial work period, be found not to be disabled.

Section 2014(a)(4)(A) provides that services rendered during a trial work period by an individual eligible solely by reason of disability are not to be considered in determining whether his disability has ceased during such period. 'Services' are defined as activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

Section 2014(a)(4)(B) defines a period of trial work as a period which begins and ends as provided in the succeeding provisions of the subsection.

Section 2014(a)(4)(C) provides that a period of trial work (with respect to any individual) will begin with the month in which such individual becomes eligible for benefits on the basis of disability. No trial work period may begin for an individual eligible on the basis of a disability if he had a previous period of trial work while eligible for benefits on the basis of the same disability.

Section 2014(a)(4)(D) provides that a period of trial work for any individual eligible on the basis of disability (beginning as provided above) will end with the ninth month in which the individual renders services (whether or not such 9 months are consecutive), or ***5324** the month in which his physical or mental impairment improves to a point where by reason of such improvement he is able to engage in substantial gainful activity, whichever is earlier.

Eligible spouse

Section 2014(b) defines 'eligible spouse' as an aged, blind, or disabled individual who is the husband or wife of another such individual. If two aged, blind, or disabled individuals are husband and wife, one will be an 'eligible individual' and the other will be an 'eligible spouse'.

Definition of child

Section 2014(c) defines a 'child' as an individual who is neither married nor the head of a household (as determined by the Secretary), and who is either (1) under age 18 or (2) under age 22 and (as determined by the Secretary) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

Determination of marital relationships

Section 2014(d) provides that in determining whether two individuals are husband and wife, appropriate State law is to be applied, except that (State law notwithstanding) they will be considered to be husband and wife for purposes of title XX if they have been determined to be husband and wife for purposes of title II of the Act or if they are found to be holding

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themselves out to the community in which they reside as husband and wife.

United States

Section 2014(e) defines the term 'United States' (when used in a geographical sense) as the States and the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Income and resources of individuals other than eligible individuals and eligible spouses

Section 2014(f)(1) provides that for purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse (other than an eligible spouse) lives with him in the same household, such individual's income and resources will be deemed to include any income, and resources of the spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

Section 2014(f)(2) provides that for purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 22, such individual's income and resources will be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who lives in the same household as such individual, whether or not the income and resources are available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

SECTION 2015. REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS

Section 2015 provides that blind and disabled individuals who are under age 65 and receiving benefits will be referred for rehabilitation ***5325** services to the State agency administering the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act, and for a review not less often than once every three months of their blindness or disability and their need for and utilization of the rehabilitation services made available to them under such plan. No such individual will be eligible for benefits under the new program if he refuses without good cause to accept vocational rehabilitation services. The Secretary is to reimburse the agency providing the rehabilitation services for the cost of such services.

SECTION 2016. OPTIONAL STATE SUPPLEMENTATION

Section 2016(a) provides that any supplementary payments based on need made by a State on a regular basis to individuals receiving payments under title XX or to individuals who would but for their income be eligible to receive such benefits will not be counted as income under the basic Federal program if (1) the Secretary and the state enter into an agreement as set forth in section 2016(b) (which may, at the option of the State, provide that the Secretary will administer such supplementary payments on behalf of the State), and (2) such supplementary payments are made in accordance with such agreement.

Section 2016(b) provides certain requirements relating to agreements between the Secretary and a State regarding State supplementary assistance payments to the aged, blind, and disabled. Such agreements must provide that in determining the eligibility for supplementary payments of an individual receiving Federal payments under title XX the income exclusions under section 2012(b) (which include the program's earnings incentives) will be applied. (The basic Federal assistance payments would however be counted in determining income for purposes of the State supplementary payments.) If this requirement is not met, the supplementary payments would be considered as unearned income for purposes of the basic Federal payments, causing a 100 percent offset in the latter; the requirement would not be applicable with respect to a person who is not receiving Federal payments, although in no case could the State supplementary payments be reduced by more than the amount of the individual's income in excess of the break-out point. If the agreement provides that the Secretary will make the supplementary payments on the State's behalf, the agreement must also provide that the supplementary payments will (subject to the provisions of subsection (c)(2)) be made to all residents in the State who receive benefits under title XX. The agreement must also provide for other rules concerning eligibility for or amount of supplementary payments, and administrative provisions, which the Secretary finds necessary to insure efficient and effective administration of both the Federal program and the State supplementary program.

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Section 2016(c)(1) permits a State, in determining eligibility for supplementary payments, to disregard up to $7.50 of any income in addition to any other amounts which it is required or permitted to exclude in determining such eligibility.

Section 2016(c)(2) provides that any State making supplementary payments under 2016(a) may at its option impose a minimum residence requirement as a condition of eligibility for such payments.

***5326** Section 2016(d) provides that States entering into agreements with the Secretary which provide for Federal administration of the State supplementary program will, at such times, and in such installments as may be agreed to by the Secretary and the State, pay to the Secretary amounts equal to the supplementary payment expenditures. Thus, subject to the hold-harmless provisions of section 503 of the bill, the State would in such a case be liable for benefit costs but not for administrative expenses.

PART B-PROCEDURAL AND GENERAL PROVISIONS

SECTION 2031. PAYMENTS AND PROCEDURES

Payment of benefits

Section 2031)a)(1) provides that benefits under title XX are to be paid at such times and in such installments as will best effectuate the purposes of the title.

Section 2031(a)(2) provides that an individual's benefit may be paid to such individual or his eligible spouse (or partly to each) or, if the Secretary deems it appropriate, to any other person-- including a public or private agency-- who is interested in the welfare of the individual or spouse.

Section 2031(a)(3) permits the Secretary to prescribe regulations establishing ranges of income within which a single amount of benefits under title XX will apply.

Section 2031(a)(4) permits the Secretary to make a cash advance of $100 or less to an applicant who is presumptively eligible and is faced with a financial emergency. In addition, in the case of a disability applicant, benefits may be paid prior to the determination of disability for a period of up to 3 months (and not considered as an overpayment) if such individual is found to be otherwise eligible for such benefits.

Section 2031(a)(5) provides that benefits for an individual who ceases to be blind or disabled are to continue through the 2nd month following the month in which the blindness or disability ceases.

Overpayments and underpayments

Section 2031(b) provides that when more or less than the correct amount of benefits has been paid to an individual, the Secretary will make proper adjustments in future payments or by recovery from or payment to such individual or his eligible spouse, or by recovery from the estate of either, with appropriate provision to avoid penalizing such individual or his eligible spouse who was without fault if adjustment or recovery would defeat the purpose of the program, be against equity or good conscience, or impede efficient or effective administration.

Hearings and review

Section 2031(c)(1) provides that the Secretary will give reasonable notice and opportunity for a hearing to any person who is or claims to be an eligible individual or eligible spouse and is in disagreement with any determination under title XX made with respect to eligibility for or the amount of benefits payable under title XX if such person requests a hearing within 30 days after receipt of the determination.

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***5327** Section 2031(c)(2) provides that determinations by the Secretary made on the basis of such a hearing (except with regard to issues of disability) must be made within 90 days after the individual requests such hearing.

Section 2031(c)(3) provides that a final determination by the Secretary after a hearing will be subject to judicial review as provided in section 205(g) of the Act, except that determinations of fact on the basis of such hearing will be conclusive and not subject to review by any court.

Procedures: prohibition of assignments

Section 2031(d)(1) provides that section 207 of the Act and subsections (a), (d), (e), and (f) of section 205 of the Act will apply with respect to benefits under title XX to the same extent as they apply to OASDI benefits. Section 207 provides that the right of any person to future payments will not be transferable or assignable or subject to execution, levy, attachment, garnishment, or other legal process. Subsections (a), (d), (e), and (f) of section 205 give the Secretary the authority to make rules and regulations concerning evidence and the submission thereof, and to issue subpoenas for the purpose of any hearing, investigation, or other procedure.

Authority to appoint special hearing examiners

Section 2031(d)(2) provides authority for the Secretary to appoint qualified people to serve as hearing examiners without their having to meet the specific standards as prescribed under the administrative procedure provisions of title 5, United States Code, for hearing examiners.

Representation of claimants

Section 2031(d)(3) grants the Secretary authority to prescribe rules and regulations for the purpose of governing the recognition of a representative on behalf of a claimant. The Secretary may prescribe maximum fees to compensate such a representative for services performed by him in connection with a claim. Any person who demands or receives any additional amount above the fee established by the Secretary for his services in representing the claimant before the Secretary is subject to a fine of up to $500, or up to 1 year's imprisonment, or both.

Applications and furnishing of information

Section 2031(e)(1) provides that the Secretary is to prescribe regulations with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances as necessary for the effective and efficient administration of the program.

Section 2031(e)(2) provides that if an individual willfully fails to report (or delays in reporting) events and changes affecting his eligibility, as required under section 2031(e)(1), the Secretary may reduce any benefits which may subsequently become payable to the individual by $25 for the first failure, $50 for the second failure, and $100 for the third and subsequent failures, except where the individual was without fault or good cause existed for such failure or delay.

***5328** Furnishing of information by other agencies

Section 2031(f) provides that the had of any Federal agency is to furnish the Secretary any information needed for determining eligibility for benefits under title XX.

SECTION 2032. PENALTIES FOR FRAUD

Section 2032 provides penalties of up to $1,000 or imprisonment for up to one year or both for individuals who deliberately

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make false statements in benefit applications, make false statements for use in determining rights to benefits, fail to disclose events which affect rights to benefits, or convert benefits received for another person to a use other than for the use and benefit of that person.

SECTION 2033. ADMINISTRATION

Section 2033 provides that the Secretary may make administrative and other arrangements to carry out his functions under the new title XX, including arrangements for determinations of blindness and disability similar to the arrangements now in effect to determine eligibility for social security disability benefits.

SECTION 2034. EVALUATION AND RESEARCH; REPORTS

Section 2034 provides that the Secretary will continually evaluate the new program, including its effectiveness in achieving its goals and its impact on related programs, and will report annually to the President and the Congress on the operations and administration of the program. The Secretary is authorized to conduct research, and contract for independent evaluations of the program, waiving requirements of the new title as he deems appropriate. He is also authorized to conduct demonstrations, and to take full advantage of established data collection, processing, and retrieval systems in carrying out his responsibilities under the section. Up to $5 million of the funds appropriated for the program could be used to carry out the evaluation and research.

SECTION 302. CONFORMING AMENDMENTS RELATING TO AID TO THE AGED, BLIND, OR DISABLED

Section 302 of the bill makes various conforming amendments in title XVI of the Act, which (in view of the enactment of the new Federal cash assistance program in title XX) will be limited to grants to States for services to the aged, blind, or disabled. These amendments eliminate the cash assistance features of title XVI and conform its language to reflect the enactment of the new title XX and the terminology used in that title.

SECTION 303. REPEAL OF TITLES I, X, AND XIV OF THE SOCIAL SECURITY ACT

Section 303 of the bill repeals titles I, X, and XIV of the Social Security Act. These titles deal with Federal grants to States for the current programs for assistance to the aged (title I), the blind (title X) and the disabled (title XIV), and are superseded by the new title XX.

***5329** SECTION 304. PROVISION FOR DISREGARDING CERTAIN INCOME IN DETERMINING NEED FOR AID TO THE AGED, BLIND, OR DISABLED FOR ASSISTANCE

Section 1007 of the **Social Security Amendments** of 1969 (as amended in July 1970 and January 1971) guarantees those receiving assistance together with railroad retirement or social security benefits after March 1970 and before January 1972 the lesser of (1) the increase in their monthly social security benefits, or railroad retirement annuities or pensions, under the **Social Security Amendments** of 1969, or (2) $4. Section 304 of the bill extends indefinitely the effective period of section 1007 of the **Social Security Amendments** of 1969.

Section 304(a) and section 304(b) of the bill makes this provision permanent with respect to optional State supplementary payments effective July 1972, and provide that a State must agree to the provision in conjunction with its agreement under section 2016 in order to have its supplementary payments excluded from income for purposes of title XX.

Section 304(b) of the bill also provides that this requirement will be deemed met if the State agrees to disregard an additional $4 of an individual's social security benefit or railroad retirement annuity or pension in determining his need.

SECTION 305. ADVANCES FROM OASI TRUST FUND FOR ADMINISTRATIVE EXPENSES

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Section 305(a) of the bill amends section 201(g)(1)(A) of the Social Security Act to provide that moneys from the four social security Trust Funds (which can now be interchanged insofar as necessary to pay for administrative expenses under the various programs, with a corrective adjustment on a fiscal year basis) will be made available to pay the administrative costs of the new program established by title XX of the Act on the same basis.

Section 305(b)(1) of the bill provides that the moneys which are appropriated in any fiscal year from the Trust Funds to pay the administrative costs of the title XX program will be repaid to the Trust Funds from time to time during or after such fiscal year from the amounts appropriated pursuant to section 2001 of the bill for funding the new title XX.

Section 305(b)(2) of the bill provides that if the Trust Funds are not repaid for expenditures advanced for administration of the title XX program in any fiscal year so that the Trust Funds are made whole as of the close of such fiscal year, the amendments made by section 305(a) will cease to be effective at the close of the fiscal year following such fiscal year and further transfers will be precluded.

Section 305(b)(3) of the bill defines 'Trust Funds' for purposes of section 305 as the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Medical Insurance Trust Fund.

***5330** TITLE IV-FAMILY PROGRAMS

ESTABLISHMENT OF OPPORTUNITIES FOR FAMILIES PROGRAM AND FAMILY ASSISTANCE PLAN

Section 401 of the bill amends the Social Security Act by adding at the end (after the new title XX added by section 301 of the bill) a new title XXI, establishing the Opportunities for Families Program and the Family Assistance Plan. The new title XXI, which includes sections 2101 through 3179, is divided into four parts: Part A (the Opportunities for Families Program), part B (the Family Assistance Plan), and parts C and D (benefit and procedural provisions which in general apply both to part A and to part B).

TITLE XXI-OPPORTUNITIES FOR FAMILIES PROGRAM AND FAMILY ASSISTANCE PLAN

PURPOSE; APPROPRIATIONS

Section 2101 provides that the purpose of title XXI is to assist needy families with children to become self-supporting and to provide them with a basic level of financial assistance necessary to encourage self-support, improve family life, and enhance personal dignity. Appropriations are authorized to carry out these objectives for five fiscal years beginning July 1, 1972, and ending June 30, 1977.

SECTION 2012. BASIC ELIGIBILITY FOR BENEFITS

Section 2102 provides that every eligible family whose employable members have registered for manpower services, training, and employment will be paid benefits by the Secretary of Labor under the Opportunities for Families Program (part A), and that eligible families in which no members are employable will be paid benefits by the Secretary of Health, Education, and Welfare under the Family Assistance Plan (part B).

PART A-OPPORTUNITIES FOR FAMILIES PROGRAM

SECTION 2111. REGISTRATION OF FAMILY MEMBERS FOR MANPOWER SERVICES, TRAINING, AND EMPLOYMENT

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Section 2111(a) provides that every member of an eligible family who is available for employment (as determined by the Secretary of Health, Education, and Welfare) must register for manpower services, training, and employment with the Secretary of Labor.

Section 2111(b) provides that an individual will not be required to register for manpower services, training, or employment if the Secretary of Health, Education, and Welfare determines that such individual is (1) unable to engage in work or training by reason of illness, incapacity, or advanced age, (2) a mother or other relative of a child under the age of three (or, until July 1, 1974, the age of six) who is caring for such child, (3) the mother of other female caretaker ***5331** of a child, if the father or another adult male relative is in the home and is not otherwise exempted from the requirement of registration, so long as such father or other adult male relative has not refused to register or to participate in work or training, (4) a child under age 16 or in school, or (5) one whose presence in the home is required because of the illness or incapacity of another member of the household. An individual who is not required to register for manpower services, training, or employment (except one who is ill, incapacitated, or aged) may nevertheless register if he so desires and will then be considered available for employment.

Section 2111(c)(1) provides that all persons who are registered for manpower services, training, or employment must accept employment in which they are able to engage as provided by regulations.

Section 2111(c)(2) provides that no individual will be required to participate in employment (A) if the job offered is vacant due to a labor dispute, (B) if the wages, hours, or other conditions of the work offered are contrary to or less than those prescribed by law, or are less favorable than those prevailing for similar work in the locality, or if the wages for the work are less than the highest Federal minimum wage (presently $1.20 per hour), (C) if, as a condition of employment, he would be required to join a company union or to resign from or refrain from joining a bona fide labor organization, or (D) if he has demonstrated the capacity of securing work or training available to him which would better enable him to achieve self-sufficiency.

SECTION 2112. CHILD CARE AND OTHER SUPPORTIVE SERVICES

Section 2112(a)(1) provides that the Secretary of Labor will arrange for child care services for individuals registered in the program who are participating in manpower services, training, or employment, or in vocational rehabilitation.

Section 2112(a)(2) authorizes the Secretary of Labor to secure child care services from all available sources and to utilize child care services provided by the Secretary of Health, Education, and Welfare to the extent possible in arranging for such services.

Section 2112(a)(3) provides that the Secretary of Labor is to provide child care services by grant or contract through public or private facilities when such services are not available through the Department of Health, Education, and Welfare. No funds available to him for this purpose may be used for the construction of facilities. Grants or contracts for child care services may be made with any agency which is designated by the appropriate official in an area and which has shown the capacity for effective cooperation with the manpower agency in the area. To the extent possible, appropriate arrangements are to be made with the local educational agency to provide care for children attending school.

Section 2112(a)(4) provides that the Secretary of Labor may require individuals receiving child care services to pay all or part of the costs (when they are able).

Section 2112(a)(5) provides that the Secretary of Labor will assure the cooperation of the manpower agency with the child care providers and prepare registered persons for employment in child care facilities.

Section 2112(a)(6) requires the Secretary of Labor to report regularly to the Secretary of Health, Education, and Welfare the amount ***5332** and location of child care services provided by grant or contract with public or private agencies.

Section 2112(a)(7) provides that at least 50 percent of the amounts appropriated for child care under part A will be expended in accordance with a formula based on the number of registered mothers in each State.

Section 2112(b)(1) provides that the Secretary of Labor is to arrange, for the health, vocational rehabilitation, counseling,

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family planning, social, and other supportive services necessary to permit registered individuals to undertake or continue manpower training and employment.

Section 2112(b)(2) provides that supportive services necessary to permit registered individuals to undertake or continue manpower training or employment are to be furnished in cooperation with the manpower training and employment services provided under part A. The Secretary of Labor is to assure that maximum use of existing facilities, programs, and agencies will be made in furnishing these services.

Section 2112(b)(3) authorizes the appropriation of not more than $100,000,000 to provide supportive services under section 2112(b) for the fiscal year ending June 30, 1973.

SECTION 2113. PAYMENT OF BENEFITS

Section 2113 provides that every eligible family under part A will be paid benefits by the Secretary of Labor.

SECTION 2114. OPERATION OF MANPOWER SERVICES, TRAINING, AND EMPLOYMENT PROGRAMS

Section 2114(a) directs the Secretary of Labor to develop an employability plan describing the manpower services, training, and employment which he determines that each registered person needs to become self-supporting. Such plans will give priority to mothers and pregnant women under 19 years old.

Section 2114(b) provides that the Secretary of Labor will establish and assure the provision of manpower services, training, and employment programs for persons registered in the program and will assure the provision of manpower services, training, and employment necessary to place participants of the program in (1) any services, training, and employment which he is authorized to provide under other Acts; (2) counseling, testing, coaching, program orientation, training, work experience, upgrading, job development, job placement, and follow-up services required to assist in securing and retaining employment and opportunities for advancement; (3) relocation assistance; and (4) public service employment programs.

Section 2114(c)(1) defines a public service employment program as a program designed to provide employment for persons not otherwise able to obtain employment or to be effectively placed in training programs. Such a program will provide employment in fields which would benefit the community the State, or the United States by improving physical, social, or economic conditions.

Section 2114(c)(2) directs the Secretary of Labor to provide for the development of employment opportunities in public service employment ***5333** programs through grants or contracts with public or nonprofit private agencies. This employment will be designed with a view toward (a) the development of employability through work experience, and (2) enabling individuals employed in these programs to move into regular public or private employment.

Section 2114(c)(3) provides that the Secretary of Labor must be assured before establishing a public service employment program, that appropriate health and safety standards are maintained; that the program will increase available employment opportunities, and will not reduce the labor costs of an employer or displace employed workers; that the conditions of work, training, education, and employment are reasonable from the standpoint of the type of work, the geographic location, and the proficiency of the participants; that workmen’s compensation is provided; and that the program will improve the employability of the participants.

Section 2114(c)(4) provides that wages paid to participants in a public service employment program will be equal to the highest of the (A) minimum wages, or (B) the prevailing rate of wages in the same labor market area for persons employed in similar public occupations, or (C) the highest Federal minimum wage (presently $1.60 per hour).

Section 2114(c)(5) requires the Secretary of Labor, at least once every six months, to review each participant’s employment record and any other pertinent information and determine whether it would be feasible to place him in regular employment or in training.

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Section 2114(c)(6) provides that payments for public service jobs may be made by the Secretary of Labor in amounts in any case not exceeding 100 percent of the cost of providing the job to the individual in the first year of employment, not exceeding 75 percent of such cost during the second year, and not exceeding 50 percent of such cost during the third year.

Section 2114(d) provides that each State or locality receiving any kind of Federal assistance through grant-in-aid programs or contracts must provide the Secretary of Labor with complete up-to-date listings of all employment vacancies that it has, as a condition for receiving such assistance.

Section 2114(e) provides that the Secretary of Labor is to work with Federal agencies administering grant-in-aid programs to establish goals for the employment of recipients of family assistance in programs supported through such Federal assistance.

Section 2114(f) authorizes the appropriation for the fiscal year 1973 of not more than $540,000,000 to carry out the manpower services, training, and employment programs under part A (other than the public service employment program) and not more than $800,000,000 to carry out the public service employment program.

SECTION 2115. ALLOWANCES FOR INDIVIDUALS UNDERGOING TRAINING

Section 2115(a)(1) directs the Secretary of Labor to pay each participant in manpower training under part A an incentive allowance of $30 per month. If one or more members of a family are eligible for a training allowance under section 203 of the Manpower Development and Training Act, the total monthly incentive allowance will be $30 ***5334** per member or the amount by which the training allowances payable under section 203 exceed the sum of the family's benefit and any State supplementary payment, whichever is greater.

Section 2115(a)(2) provides that the Secretary of Labor will pay, to any participant in manpower training under part A, allowances for transportation and other expenses reasonably necessary for and directly related to such training.

Section 2115(b) provides that allowances under section 2115(a) are to be in lieu of allowances provided under any manpower training program under any other Act.

Section 2115(c) provides that allowances under section 2115(a) will not be payable to any person who is participating in a program providing on-the-job training sponsored by the Secretary of Labor or who is participating in manpower training which has the purpose of obtaining for him an undergraduate or graduate degree at a college or university.

SECTION 2116. UTILIZATION OF OTHER PROGRAMS

Section 2116 authorizes the Secretary of Labor, using all authority granted to him under any other Act, to provide the manpower training and employment services required by part A in such manner as will further the establishment of an integrated and comprehensive manpower training program.

SECTION 2117. REHABILITATION SERVICES FOR INCAPACITATED FAMILY MEMBERS

Section 2117(a) provides that any family member receiving benefits under part A who is not required to register due to an incapacity will be referred for vocational rehabilitation services under the Vocational Rehabilitation Act. The Secretary of Labor is required to review such individual's continued need for and use of rehabilitation services at least once each quarter.

Section 2117(b) provides that any family member who is referred for vocational rehabilitation services under a State plan approved under the Vocational Rehabilitation Act is required to accept such services, except where good cause exists for failure to do so, and that the Secretary of Labor will pay to the State agency administering the State plan the costs incurred in the provision of such services.

Section 2117(c) provides that the Secretary of Labor will pay each family member receiving vocational rehabilitation services under section 2117(a) an incentive allowance of $30 per month, and an allowance for transportation and other

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necessary costs related to participation in vocational rehabilitation; these allowances are in lieu of allowances provided for participants in vocational rehabilitation services under any other Act.

SECTION 2118. EVALUATION AND RESEARCH; REPORTS

Section 2118(a)(1) directs the Secretary of Labor to provide for the continuing evaluation of the program under part A. He may conduct research and demonstration projects concerning ways to improve the effectiveness of the program and contract for independent evaluation and research.

***5335** Section 2118(a)(2) authorizes the appropriation, for the costs of the evaluation and research provided for in section 2118(a)(1), of up to $10,000,000 for any fiscal year.

Section 2118(b) directs the Secretary of Labor to utilize, in conducting these activities, the data collection, processing, and retrieval system established for general administrative use in connection with the part A program.

Section 2118(c) directs the Secretary of Labor to make an annual report to the President and the Congress, evaluating and making recommendations on the operation and administration of the program.

PART B-FAMILY ASSISTANCE PLAN

SECTION 2131. PAYMENT OF BENEFITS

Section 2131 provides that the Secretary of Health, Education, and Welfare is to pay benefits to eligible families in which no member is available for employment.

SECTION 2132. REHABILITATION SERVICES FOR INCAPACITATED FAMILY MEMBERS

Section 2132(a) provides that any family member receiving benefits under part B who was not required to register for manpower services, training, and employment under part A because of an incapacity will be referred by the Secretary of Health, Education, and Welfare for vocational rehabilitation services under the Vocational Rehabilitation Act. Except in cases of permanent incapacity, the Secretary is required to make a periodic review, no less often than once per quarter, of such member's continued need for and use of such rehabilitation services.

Section 2132(b) provides that any family member who is referred for vocational rehabilitation services under a State plan approved under the Vocational Rehabilitation Act is required to accept such services except where good cause exists for failure to do so; and that the Secretary of Health, Education, and Welfare will pay to the State agency administering the State plan the costs incurred in providing the services.

Section 2132(c) provides an incentive allowance of $30 a month and allowances for transportation and other expenses arising from participation in vocational rehabilitation services. These allowances are in lieu of similar allowances provided under any other Act.

SECTION 2133. CHILD CARE AND OTHER SUPPORTIVE SERVICES

Section 2133(a)(1) provides for child care services for individuals referred for and participating in vocational rehabilitation services.

Section 2133(a)(2) directs the Secretary of Health, Education, and Welfare to arrange for all necessary child care services, including transportation, from all available sources but giving priority to facilities developed under section 2134.

Section 2133(a)(3) authorizes the Secretary of Health, Education, and Welfare to provide child care services by grant or

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contract with public or private facilities when these services are not available through facilities developed by the Secretary under section 2134. Such facilities may include those operated by an agency which is ***5336** designated by the appropriate official in the area and which has shown its capacity for effective cooperation with the manpower agency in the area. To the extent possible, appropriate arrangements are to be made with the local educational agency to provide child care for children attending school.

Section 2133(a)(4) provides that the Secretary may require individuals participating in vocational rehabilitation to pay all or part of the costs (if they are able).

Section 2133(b) directs the Secretary of Health, Education, and Welfare to offer family planning services to appropriate members of families registered under part A, with the acceptance of such services being voluntary and not a prerequisite of benefit eligibility.

SECTION 2134. STANDARDS FOR CHILD CARE; DEVELOPMENT OF FACILITIES

Section 2134(a) directs the Secretary of Health, Education, and Welfare with the concurrence of the Secretary of Labor to set standards for the quality of child care services, to set schedules of reasonable fees for families who are able to pay for part or all of the cost of these services, and to coordinate child care services under title XXI with other available child care and social services.

Section 2134(b)(1) authorizes the Secretary of Health, Education, and Welfare to construct child care facilities through grants or contracts with public and private nonprofit agencies.

Section 2134(b)(2) defines ‘construction‘ as the acquisition, alternation, remodeling, or renovation-- as well as construction-- of facilities for child care.

Section 2134(b)(3) calls for reimbursement to the Government when, within twenty years of its completion, a child care facility constructed with Federal funds is no longer owned by a public or nonprofit private agency, or is no longer used for the purpose for which it was constructed. The amount recoverable will be in the same ratio to the then value of the facility as the ratio which the amount of Federal funds bore to the total cost of construction of the facility.

Section 2134(b)(4) provides that laborers and mechanics employed on construction projects must be paid at least the rate of wages prevailing in the locality, in accordance with the Davis-Bacon Act.

Section 2134(b)(5) limits appropriations for construction of child care facilities under these provisions to $50,000,000 in any fiscal year.

Section 2134(c) provides that the Secretary of Health, Education, and Welfare may make grants to any public or private non-profit agency or organization, or contracts with any private or public agency or organization, for part or all of the planning costs, establishment of facilities, operating costs for 24 months or longer if necessary, evaluation, training of personnel technical assistance, and research or demonstration projects to determine more effective methods of providing child care.

SECTION 2135. EVALUATION AND RESEARCH; REPORTS

Section 2135(a)(1) directs the Secretary of Health, Education, and Welfare to provide for the continuing evaluation of the program under part B. He may conduct research and demonstration projects concerning ways to improve the effectiveness of the program and contract for independent evaluation and research.

***5337** Section 2135(a)(2) authorizes the appropriation for the costs of the evaluation and research provided for in section 2135(a)(1), of up to $10,000,000 for any fiscal year.

Section 2135(b) provides that the Secretary of Health, Education, and Welfare is to utilize, in conducting these activities, the

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data collection, processing, and retrieval system established for general administrative use in connection with the part B program.

Section 2135(c) provides that the Secretary of Health, Education, and Welfare is to report annually to the President and the Congress, evaluating and making recommendations on the operation and administration of the program.

PART C-DETERMINATION OF BENEFITS

SECTION 2151. DETERMINATIONS; REGULATIONS

Section 2151 provides that the regulations dealing with determinations of eligibility and amount of benefits under the Family Assistance Program (part B) and the Opportunities for Families Program (part A) will be prescribed by the Secretary of Health, Education, and Welfare with the concurrence of the Secretary of Labor. The regulations are to be designed to assure that, to the extent possible, determinations of eligibility, and assistance payment amounts will be uniform under the two programs. The term ‘Secretary‘ when used alone means the Secretary of Labor with respect to part A and the Secretary of Health, Education, and Welfare with respect to part B.

SECTION 2152. Eligibility FOR AND AMOUNT OF BENEFITS

Definition of eligible family

Section 2152(a) provides that each family (as defined in section 2155) whose non-excludable income under section 2153(b) is less than $800 per year for each of the first two family members, plus $400 per year for each of the next three members, plus $300 per year for each of the next two members, plus $200 for the next member, and whose resources other than those excluded under section 2154 are less than $1,500, will be an eligible family for purposes of title XXI.

Amount of benefits

Section 2152(b) provides that the amount of a family’s assistance benefit will be $800 per year for each of the first two family members, plus $400 per year for each of the next three members, plus $300 per year for each of the next two members, plus $200 for the next member, reduced by the amount of the family’s income not excluded under section 2153(b). However, no benefit will be paid if the rate of payment is less than $10 per month.

Exclusion of certain family members

Section 2152(c) provides that if a family member who is available for employment fails to register as required under section 2111(a), or fails to accept services or employment or participate in training as required under section 2111(c), or if a family member fails to accept rehabilitation services as required under section 2117(b) or 2132(b), the family’s benefits will be reduced by $800 per year in the case of each of the first two such members, by $400 per year in the case of ***5338** each of the next three such members, by $300 per year in the case of the next two such members, and by $200 per year in the case of the next such member; or by proportionately smaller amounts for shorter periods.

Payment of benefits; period for determination of benefits

Section 2152(d)(1) provides that payment of a family’s assistance benefits under part A or B, and the amount of such benefits, will be determined for each calendar quarter by the Secretary on the basis of his estimates of the family’s income for each quarter, taking into account income for preceding quarters and any likely changes in conditions which would affect the family’s eligibility or the amount of the benefits. Redeterminations for any calendar quarter are to be made at such times as the Secretary receives notice, or has reason to believe, that a material change has occurred.

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Section 2152(d)(2) provides that the benefit amount payable to a family for any quarter is to be determined in the quarter following that quarter; adjustment will be made if the amount that was estimated and paid was more or less than the actual amount determined payable. Benefits will be adjusted by any income received by a family member in the quarter in which determination is made and in any of the three quarters preceding the quarter for which the determination was made which was not already counted as income for benefit purposes.

Section 2152(d)(3) provides that income received in the first quarter preceding the quarter in which a determination is made will be considered first in reducing the amounts of a family's benefit because of an overpayment based on an estimate, followed by income in the second and third quarters preceding it if benefits are still payable after each reduction is made. Such income is to be subject to the exclusions prescribed by section 2153(b). Where a family did not receive benefits in each of the three preceding quarters, the Secretary may estimate any amount needed for benefit determination under section 2152(d)(2).

Section 2152(d)(4) provides that the Secretary is to establish by regulation when and to what extent the benefit for any quarter may be reduced of the lapse of time between the beginning of the quarter and the date of filing an application for benefits.

Section 2152(d)(5) provides that an application for benefit filed on any day in a month will be deemed to have been filed on the first day of that month.

Biennial reapplication

Section 2152(e) provides that after a family has been paid benefits for 24 consecutive months, no additional benefits are to be paid to such family under either part A or part B until such family has filed a new application and has had its eligibility for benefits redetermined on the basis of that application.

Special limits on gross income

Section 2152(f) provides that the Secretary by regulation may prescribe circumstances under which gross income from a trade or business (including farming) is large enough to preclude eligibility for benefits. (The term 'gross income' has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954.)

***5339** Certain individuals ineligible

Section 2152(g)(1) provides that no family will be eligible family if any family member fails within 30 days after notification by the Secretary to take all necessary steps to apply for and (if eligible) obtain any other benefits due him under the Act or any similar payments for which the Secretary has notified him he may be eligible.

Section 2152(f)(2) provides that an individual who is incapacitated solely because of drug or alcohol abuse will be considered a family member only if he is undergoing treatment (if available) at an institution or facility approved by the Secretary. The Secretary is to assure himself that such family members are undergoing treatment, and will report annually to the Congress on his activities in this area.

Puerto Rico, the Virgin Islands, and Guam

Section 2152(h) is a cross-reference to section 1108(e) of the Act (discussed below under section 503 of the bill), which sets out the special method by which benefits are to be determined for families in Puerto Rico, the Virgin Islands, and Guam.

SECTION 2153. INCOME

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Meaning of income

Section 2153(a) provides that for purposes of title XXI, income means both earned and unearned income.

Earned income is defined in paragraph (1) as--

(A) wages within the meaning of section 203(f)(5)(C) of the Act, relating to the social security earnings test; and

(B) net earnings from self-employment as defined in section 211 of the Act (except for that part of section 211 which deals with optional definitions of net earnings), including earnings derived from certain services performed by ministers, Christian Science practitioners, and members of religious orders, and by certain members of religious faiths who have received an exemption from coverage.

Section 2153(a)(2) defines unearned income as all income other than earned income (as defined in paragraph (1)), including specifically support and maintenance furnished in case or otherwise; any payments received as annuity or as pension, retirement, or disability benefits, veterans' or workmen's compensation, old-age survivors, and disability insurance benefits, railroad retirement benefits, or unemployment benefits; prizes and awards; life insurance policy proceeds (in excess of the amount expended by family members for last illness and burial expenses or $1,500, whichever is less); gifts (cash or otherwise); support and alimony payments, and inheritances; and rents, dividends, interests, and royalties.

Exclusions from income

Section 2153(b) provides that the following are to be excluded in determining a family's income:

(1) earned income of a child regularly attending school, subject to limitations (as to amount or otherwise) prescribed by the Secretary;

(2) the total unearned income of the family in a calendar quarter which (as determined under criteria prescribed by the Secretary) is received too infrequently or irregularly to be included, if such unearned income does not exceed $60 in the quarter, and the total earned income of the family in a calendar quarter which (as determined under such criteria) is received too irregularly or infrequently to be included, ***5340** if such earned income does not exceed $30 in the quarter;

(3) part or all of any earned income which (under regulations prescribed by the Secretary) is necessary to pay the cost of child care so that the family member incurring such cost can participate in manpower training, vocational rehabilitation, employment, or self-employment;

(4) the first $720 a year (or proportionately smaller amounts for shorter periods) of the total earned income (not previously excluded) of all family members, plus one-third of the remainder;

(5) subject to section 2156, any assistance (except veterans' pensions) which is based on need and is received from a State, political subdivision of a State, Federal agency, or private agency or organization exempt from taxation under section 501 of the Internal Revenue Code of 1954;

(6) training and other allowances provided under the new sections 2115(a), 2117(c), or 2132(c), and similar allowances (up to $30 a month) paid by a State or locality to family members receiving Federal benefits;

(7) the tuition and fees portion of any grant, scholarship, or fellowship at an educational institution (including technical or vocational education);

(8) home produce produced and used by the family;

(9) one-third of any support and alimony payments; and

(10) any amounts received for the foster care of a child who is living in the same home as the family but who is not a family

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member.

Section 2153(b) further provides that the total excludable amounts under paragraphs (1), (2), and (3) may not exceed the lesser of $2,000 plus $200 for each family member in excess of four, or $3,000, or a proportionately smaller amount for a shorter period.

SECTION 2154. RESOURCES

Exclusions from resources

Section 2154(a) provides that, in determining a family's resources, its home, household goods, and personal effects are to be excluded to the extent their total value does not exceed a reasonable amount as determined by the Secretary, along with any other property which the Secretary determines by regulation is essential to the family's means of self-support. An individual's life insurance policies are to be considered as resources to the extent of their cash surrender value, or excluded altogether if their total face value is $1,500 or less.

Disposition of resources

Section 2154(b) directs the Secretary, by regulation to prescribe the period of periods within which, and the manner in which, a family's property must be disposed of in order not to be included in determining the family's eligibility for benefits. Any benefits paid during such a period are to be conditioned on such disposal and considered over payments (and therefore recoverable) to the extent that they would ***5341** not have been paid had the disposal occurred at the beginning of the period for which the benefits were paid.

SECTION 2155. MEANING OF FAMILY AND CHILD

Composition of family

Section 2155(a) defines a family as two or more people who are related by blood, marriage, or adoption and who are residents of the United States (with at least one being a citizen or a lawfully admitted resident alien) living together in a place of residence maintained as a home by one or more of them. At least one of the family members must be a child in the care of, or dependent upon, another family member. A parent (of a child living in the place of residence), or a spouse of such a parent, who is determined by the Secretary to be temporarily absent from the place of residence in order to engage in or seek employment or while he is in the military service is to be considered as living in the residence. Groups in households headed by students regularly attending a college or university are not to be considered as families. A person remaining outside the United States for 30 days may not be considered a family member; he will be considered inside the United States only when he has been in the United States again for 30 consecutive days.

Meaning of child

Section 2155(b) defines a child as an individual who is neither married nor the head of a household, and is under age 18 or is under age 22 and (as determined by the Secretary under regulations) a student regularly attending school, college, or university or a course of training in preparation for employment.

Determination of family relationships

Section 2155(c) provides that in determining whether two individuals are related by blood, marriage, or adoption, appropriate State law is to be applied.

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Income and resources of non-contributing individual

Section 2155(d) provides that the income and resources of an individual other than a parent or the spouse of a parent which (as determined under criteria prescribed by the Secretary) is not available to other members of the family is to be excluded in determining the family's eligibility for and amount of benefits, and an individual (other than such a parent or spouse) any of whose income and resources is not available to a family will not be considered a member of the family (except that if such individual is a child who would otherwise be considered a member of the family, he will be considered a member of the family for purposes of determining the family's eligibility but not the amount of its benefits).

United States

Section 2155(e) defines 'United States' (when used in a geographic sense) as the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Recipients of aid to the aged, blind, and disabled ineligible

Section 2155(f) provides that an individual who is receiving aid to the aged, blind, and disabled under title XX of the Act (as added by ***5342** section 301 of the bill) will not be considered a member of a family for purposes of determining the amount of the family benefits under title XXI and his income and resources are not to be counted as income to such family.

SECTION 2156. OPTIONAL STATE SUPPLEMENTATION

Section 2156(a) provides that any supplementary payments based on need made by a State on a regular basis to family members receiving payments under title XXI or to individuals who would but for their income be eligible to receive such benefits will not be counted as income under the basic Federal program if (1) the Secretary and the State enter into an agreement as set forth in section 2156(b) (which may, at the option of the State, provide that the Secretary will administer such supplementary payments on behalf of the State), and (2) such supplementary payments are made in accordance with such agreement.

Section 2156(b) provides certain requirements relating to agreements between the Secretary and a State regarding State supplementary assistance payments to families under the program. Such agreements must provide that in determining the eligibility for supplementary payments of an individual receiving Federal payments under title XXI the income exclusions under section 2153(b) (which include the program's earnings incentives) will be applied. (The basic Federal assistance payments would however be counted in determining income for purposes of the State supplementary payments.) If this requirement is not met, the supplementary payments would be considered as unearned income for purposes of the basic Federal payments, causing a 100-percent offset in the latter; the requirement would not be applicable with respect to a family which is not receiving Federal payments, although in no case could the State supplementary payments be reduced by more than the amount of the family's income in excess of the break-out point. If the agreement provides that the Secretary will make the supplementary payments on the State's behalf, the agreement must also provide that the supplementary payments will (subject to the provisions of subsection (c)) be made to all residents in the State who receive benefits under this title XXI. The agreement must also provide for other rules concerning eligibility for or amount of supplementary payments, and administrative provisions, which the Secretary finds necessary to insure efficient and effective administration of both the Federal program and the Federal program and the State supplementary program.

Section 2156(c) provides that any State making supplementary payments under 2156(a) may at its option impose a minimum residence requirement as a condition of eligibility for such payments.

Section 2156(d) provides that States entering into agreements with the Secretary which provide for Federal administration of the State supplementary program will, at such times and in such installments as may be agreed to by the Secretary and the State, pay to the Secretary amounts equal to the supplementary payment expenditures. Thus, subject to the hold harmless provisions of section 503 of the bill, the State would in such a case be liable for benefit costs but not for administrative expenses.

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***5343** PART D-PROCEDURAL AND GENERAL PROVISIONS

SECTION 2171. PAYMENTS AND PROCEDURES

Payment of benefits

Section 2171(a)(1) provides that family assistance benefits are to be paid at such time or times and in such installments as may be determined by the Secretary.

Section 2171(a)(2)(A) authorizes the Secretary to pay a family's benefit to one or more members of the family, or, if he finds it would be contrary to the welfare of the family and so notifies and provides an opportunity for a hearing to those who otherwise would be paid, to a non-family-member or other person (including an appropriate public or private agency) who is interested in or concerned with the family's welfare. The Secretary will investigate each case in which there is reason to believe that payment to such a non-family member or other person may be indicated.

Section 2171(a)(2) provides that where a family's benefits are paid to a representative payee, the Secretary is required to periodically review the need for such payee and, where the need no longer exists, to discontinue payments to such payee. If the Secretary finds that the conditions under which payment is being made to a representative payee are likely to continue beyond a period specified by him, he is required to attempt to secure the appointment of a guardian or other legal representative for the family member (or members) for whom the payment is being made and to take any other steps he finds appropriate to protect the welfare of the child (or children) in the family.

Section 2171(a)(2)(C) provides that where the Secretary finds the family member who would otherwise be paid has failed to register for manpower services or employment under section 2111(a) or to accept manpower services under section 2111(c) or to accept rehabilitation services under section 2117(b) or 2132(b), he may not pay the family benefits to that family member; and if he makes the payments to a non-family-member he may do so without making a determination of inability on the part of the person who would otherwise be paid.

Section 2171(a)(3) allows the Secretary to prescribe regulations establishing ranges of income within which single amounts of family benefits will apply.

Section 2171(a)(4) allows the Secretary to make an emergency cash assistance payment of no more than $100 to a family initially applying for benefits where he determines that such emergency assistance is needed. Such payments are to be deducted from future benefits.

Overpayments and underpayments

Section 2171(b) provides that when more or less than the correct amount of benefits has been paid to a family the Secretary will make adjustments by increases in future payments or by recovery from or payment to one or more individuals who are or were members of the family, with appropriate provision to avoid penalizing family members who were without fault if adjustment or recovery would defeat the purpose of the program be against equity or good conscience, or impede efficient or effective administration.

***5344** Hearings and review

Section 2171(c)(1) provides that the Secretary will give reasonable notice and opportunity for a hearing to any person who is or claims to be a family member and is in disagreement with a determination on eligibility for benefits, the amount of the benefits, the number of persons in the family, or the refusal of such person to participate or to continue participating in manpower services, training, or employment, or to accept employment, or rehabilitation services, if a request for such hearing is made within thirty days after notice of the determination is received.

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Section 2171(c)(2) provides that a determination by the Secretary must be made within ninety days after the individual requests a hearing.

Section 2171()(3) provides that a final determination by the Secretary after such a hearing will be subject to judicial review as provided in section 205(g) of the Act except that all determinations of fact on the basis of such hearings will be conclusive and not subject to review by any court.

Procedures; prohibition of assignments; representation of claimants

Section 2171(d)(1) provides that section 207 of the Act, and subsections (a), (d), (e), and (f) of section 205 of the Act, will apply with respect to family assistance benefits to the same extent as they apply to OASDI benefits. Section 207 of the Act provides that the right of any person to future payments will not be transferable or assignable or subject to execution, levy, attachment, garnishment, or other legal process. Subsections (a), (d), (e), and (f) of section 205 of the Act give the Secretary the authority to make rules and regulations concerning evidence and the submission thereof, and to issue subpoenas for the purpose of any hearing, investigation, or other procedure.

Section 2171(d)(2) provides the Secretary with the authority to appoint hearings examiners, based on qualifications set by him. Such qualifications need not meet the specific standards prescribed for hearings examiners under the administrative procedure provisions of title 5, United States Code.

Section 2171(d)(3) authorizes the Secretary to prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys, representing claimants before him. An attorney in good standing who is admitted to practice before the highest court of the State, Territory District, or insular possession of his residence, or before the U.S. Supreme Court or other Federal courts, will be entitled to represent claimants. Any claimant's representative who refuses to comply with the Secretary's rules and regulations or who violates any provision of this section for which a penalty is prescribed may be suspended or prohibited from further practice before the Secretary. Where a claimant has been given a favorable decision and has been represented, the Secretary is required to set a reasonable fee to compensate the representatives. Where it is determined that a person, with intent to defraud, willfully and knowingly deceives, misleads, or threatens any claimant or prospective claimant or beneficiary, or knowingly charges or collects any fee in excess of that set by the Secretary, such person will be deemed to be guilty of a misdemeanor and, upon conviction, will be fined in an amount not exceeding $500 or imprisoned for a period not exceeding one year or both.

***5345** Applications and furnishing of information by families

Section 2171(e)(1) provides that the Secretary is to prescribe regulations with respect to the filing of applications, the suspension or termination of benefits, the furnishing of information, and the reporting of events and circumstances, as necessary to determine eligibility for and amount of benefits.

Section 2171(e)(2) provides that each family who receives benefits under part A or part B in a quarter is required to submit information to enable the Secretary to redetermine eligibility for and amount of benefits payable. Failure by the family to submit such report not later than 30 days after the close of the quarter will result in suspension of benefits.

Section 2171(e)(3) provides that in case of failure to submit any other data, material, or report required under section 2717(e)(1), or willful delay in submitting such data, material, or report, any benefits which may subsequently become payable will be reduced by--

(A) $25 for the first failure or delay

(B) $50 for the second failure or delay, and

(C) $100 for the third or a subsequent failure or delay, except where the family is without fault or there was good cause for such failure or delay.

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Furnishing of information by other agencies

Section 2717(f) requires the head of any Federal agency to furnish the Secretary any information needed for determining eligibility for or amount of family benefits or for verifying other information.

SECTION 2172. PENALTIES FOR FRAUD

Section 2172 imposes a penalty of $1,000 or one year imprisonment, or both, upon conviction for fraud under the new programs.

SECTION 2173. ADMINISTRATION

Section 2173 provides that the Secretary of Health, Education, and Welfare and the Secretary of Labor may each perform any of his functions under title XXI (or under section 1124 of the Act, discussed below, relating to determinations of medicaid eligibility) directly, or by arrangements or contracts providing for payment in advance or by way of reimbursement, and in such installments as he may deem necessary.

SECTION 2174. ADVANCE FUNDING

Section 2174(a) provides that appropriations for grants, contracts, and other payments under parts A and B (other than benefit payments) may be included in the appropriation act for the fiscal year preceding the fiscal year for which they are to be used.

Section 2174(b) provides that in order to effect a transition to the advance funding procedure, two separate appropriations may initially be made in the same fiscal year, one for that fiscal year and one for the following fiscal year.

***5346** SECTION 2175. OBLIGATION OF DESERTING PARENTS

Section 2175 provides that receipt of benefits under title XXI by the spouse or children of a deserting parent during his absence will result in a monetary obligation to the United States by the deserting parent equal to the total amount of the benefits received under title XXI by the deserting parent's spouse and children. The obligation would be reduced by any payments which he actually makes to his family during the period and which are excluded in computing the family assistance benefits paid to his spouse and children; and in no case would his obligation exceed the amount (if any) ordered by a court of competent jurisdiction for the support and maintenance of his spouse or children, less any payments made under such order. The amount due the United States is to be collected from any amounts otherwise due or becoming due the deserting parent from any officer or agency of the United States or under any Federal program.

SECTION 2176. PENALTY FOR INTERSTATE FLIGHT TO AVOID PARENTAL RESPONSIBILITIES

Section 2176 provides that the parent of a child receiving benefits under title XXI who moves in interstate commerce to avoid responsibility for the support of such child, or any other legal obligation he has as the parent of such child, is guilty of a misdemeanor and upon conviction will be fined not more than $1,000, or imprisoned for not more than one year, or both.

SECTION 2177. REPORTS OF IMPROPER CARE OR CUSTODY OF CHILDREN

Section 2177 provides that whenever the Secretary obtains information which gives him reason to believe that any child is being or has been subjected to neglect, abuse, exploitation, or other improper care or custody he will make a report to the State or local child welfare agency and to the head of the appropriate Federal agency.

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SECTION 2178. ESTABLISHMENT OF LOCAL COMMITTEES TO EVALUATE EFFECTIVENESS OF MANPOWER AND TRAINING PROGRAMS

Section 2178(a) provides that the Secretary of Health, Education, and Welfare and the Secretary of Labor will jointly establish local advisory committees throughout the United States to evaluate and report on the effectiveness of the training, employment, child care, and related aspects of the programs under title XXI which are designed to help recipients to become self-supporting. At least one such committee would be established in each State.

Section 2178(b) provides that each local committee will have representation of labor, business, the general public, and units of local government not directly involved in administering the programs. The chairman will be selected by the committee from its membership.

Section 2178(c) requires the local committees to submit reports on the effectiveness of the programs to the Secretaries at regular intervals, together with recommendations for improving the programs.

Section 2178(d) directs the Secretaries to provide for each local committee reasonable expenses for its members. It further authorizes appropriations to carry out these provisions.

***5347** SECTION 2179. INITIAL AUTHORIZATION FOR APPROPRIATIONS FOR CHILD CARE SERVICES

Section 2179 authorizes the appropriation for the fiscal year 1973 of a total of $700,000,000 for child care under parts A and B (including grants under section 2134(c). (This figure does not include the $50,000,000 authorized annually by section 2134 for the development of child care facilities.)

SECTION 402, CONFORMING AMENDMENTS RELATING TO AID TO FAMILIES WITH DEPENDENT CHILDREN

Section 402 of the bill makes various conforming amendments in part A of title IV of the Social Security Act, which (in view of the enactment of the new Federal cash assistance program in title XXI) will be limited to grants to States for services to needy families with children and payments for foster care. These amendments eliminate the cash assistance features of part A of title IV and conform its language to reflect the enactment of the new title XXI and the terminology used in that title. For purposes of foster care payments under part A of title IV as amended, ‘foster care‘ includes only foster care which is provided on behalf of a child (1) who is removed from the home by court order (2) whose placement and child care are the responsibility of the State or local agency (or another public agency selected by it), (3) who has been placed in a foster home or child-care institution and (4) who is receiving assistance at the time of the court order or would have received assistance if an application had been filed.

TITLE V-MISCELLANEOUS

PART A-EFFECTIVE DATES AND GENERAL PROVISIONS

SECTION 501. EFFECTIVE DATE FOR TITLES III AND IV

Section 501 of the bill provides that the amendments and repeals made by titles III and IV of the bill, and by this part and parts B and E of title V, will become effective (and section 9 of the Act of April 19, 1950 (25 U.S.C. 639), which authorizes payments to States in addition to those authorized in sections 3(a), 403(a), and 1003(a) of the Social Security Act, is repealed) on July 1, 1972, except as otherwise specifically indicated, and except that--

(1) sections 2133 and 2134 of the new title XXI (relating to child care) will become effective on enactment;

(2) the new title XXI insofar as it applies to the working poor will not become effective until January 1, 1973; and

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(3) appropriations to develop and place in operation the new programs under titles XX and XXI during the fiscal year ending June 30, 1972, may be included in an appropriation Act for that fiscal year.

***5348** SECTION 502. PROHIBITION AGAINST PARTICIPATION IN FOOD STAMP PROGRAM BY RECIPIENTS OF PAYMENTS UNDER FAMILY AND ADULT ASSISTANCE PROGRAMS

Section 502(a) of the bill amends the Food Stamp Act of 1964 to provide that adults and family members who have been determined to be eligible for benefits under the new title XX or the new title XXI will not be eligible for food stamps.

Sections 502(b) through (f) of the bill make various changes in the Food Stamp Act of 1964 to reflect the amendment made by section 502(a) and the repeal by the bill of the present Federal-State cash programs.

Section 502(g) of the bill provides that these amendments will become effective July 1, 1972 (when the new Federal programs go into effect); except that the Secretary of Health, Education, and Welfare is authorized to postpone the effective date of these amendments for up to 30 days with respect to persons becoming eligible under the new programs at the outset, and with respect to persons qualifying under those programs thereafter in order to avoid the interruption of their income in the transition to such programs.

SECTION 503. LIMITATION ON FISCAL LIABILITY OF STATES FOR OPTIONAL STATE SUPPLEMENTATION

Section 503 of the bill guarantees, in general, that where a State chooses to have its supplementary payment program administered by the Federal Government its cash expenditures for welfare in 1971.

Section 503(a)(1) of the bill provides that the amount payable for any fiscal year to the Secretary by a State under the State's agreements to supplement Federal payments as provided for under sections 2016 and 2156 of the Act, where the State's supplementary payment program is being federally administered, will not exceed the States non-Federal share of expenditures as aid and assistance in the calendar year 1971 under the Federal-State programs provided for in titles I, X, XIV, and XVI, and part A of title IV, of the Act.

Section 503(a)(2) of the bill provides that the limitation provided for in section 503(a)(1) on the amount payable to the Secretary by a State for its supplementary payments in any fiscal year will apply only with respect to that portion of the supplementary payments in such fiscal year which does not exceed, in the case of any individual or family, the difference between (A) the adjusted payment level under the appropriate State plan as in effect for January 1971 (as defined in section 503(b)), and (B) the Federal payments in such fiscal year to adults and families under the new titles XX and XXI, plus income not excluded under section 2012(b), or 2153(b) thereof; and will apply only with respect to supplementary payments to an individual or family who is required to be included for payments under the agreement between the State and the Secretary and who would have been eligible, if he had met the income test, for payments under the State plan as in effect for January 1971.

Section 503(b)(1) of the bill defines the term 'adjusted payment level' as the amount of the money payment which an individual or family with no other income would have received under the State ***5349** plan in effect for January 1971, except that the State may, at its option, increase such payment level by an amount which does not exceed the sum of (A) a payment level modification (as defined in section 503(b)(2)) with respect to such plan, and (B) the bonus value of food stamps in such State for January 1971 (as defined in section 503(b)(3)).

Section 503(b)(2) of the bill defines the term 'payment level modification' as the amount by which a State which, for January 1971, made payments which were below 100 percent of its standard of need, could have increased its money payments, and reduced its standard of need so that the increased payments equaled 100 percent of its standard of need, without increasing its non-Federal share of expenditures for old-age assistance, aid to the blind, aid to the totally and permanently disabled, and aid to families with dependent children in the calendar year 1971.

Section 503(b)(3) of the bill defines the bonus value of food stamps in a State, with respect to an individual or family whose income was equal to the adjusted payment level under the State plan (including any payment level modification with respect

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to the plan adopted under section 503(b)(2) of the bill but not including the face value of the food stamps themselves), as the total face value of the food stamp coupon allotment which would have been provided to such an individual or family for January 1971 reduced by the charge which such individual or family would have had to pay therefor. The total face value of the food stamps and the charge to the recipient in January 1971 are to be determined in accordance with the rules prescribed by the Secretary of Agriculture in effect in that month.

Section 503(c) of the bill defines the non-Federal share of expenditures for money payments under a State's plan approved under title I, X, XIV, or XVI, or part A of title IV, of the Act, for the calendar year 1971, as the difference between (1) the total amount of such expenditures for such year (excluding emergency assistance under section 406(e)(1)(A), foster care under section 408, expenditures authorized under section 1119 of the Act for home repairs, and benefits in the form of institutional services in intermediate care facilities under section 1121), and (2) the amounts of such expenditures for 1971 paid to the State by the United States under the formula for Federal matching under sections 3, 403, 1003, 1403, and 1603, and section 1118, of the Act, and section 9 of the Act of April 19, 1950. Thus, in effect, the non-Federal share of expenditures is the total amount expended by the State for cash payments minus the amount of Federal payments to the State with respect thereto.

SECTION 504. SPECIAL PROVISIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Section 504 of the bill adds to section 1108 of the Social Security Act a new subsection (e) which provides (in paragraph (1)) that in Puerto Rico, the Virgin Islands, and Guam--

(1) the eligibility level for and amount of adult and family assistance benefits (except for the special benefit amounts for those hospitalized),

(2) the irregular income excluded,

(3) the resources limitations, and

***5350** (4) certain other dollar amounts (not including the work incentives disregards or the incentive allowances for those receiving certain services), will be reduced in proportion to the extent by which the per capita income of each is below that one of the 50 States which has the lowest per capita income.

The new section 1108(e)(2)(A) provides that the Secretary will promulgate the amounts to be used in regard to Puerto Rico, the Virgin Islands, and Guam between July 1 and September 30 of each odd-numbered year, on the basis of the average per capita income of each State for the most recent calendar year satisfactory data are available from the Department of Commerce. The Secretary's promulgation will be effective for each of the two fiscal years in the period beginning July 1 next succeeding the promulgation.

The new section 1108(e)(2)(B) provides that the term 'State' means any of the fifty States and the District of Columbia.

The new section 1108(e)(3) of the bill provides that the amounts promulgated for Puerto Rico, the Virgin Islands, and Guam for any fiscal year will in no case be lower than the amounts promulgated for them for the immediately preceding period.

SECTION 505. DETERMINATIONS OF MEDICAID ELIGIBILITY

Section 505 of the bill adds to title XI of the Social Security Act a new section 1124, which authorizes the Secretary of Health, Education, and Welfare to enter into agreements with States under which he (or the Secretary of Labor in the case of beneficiaries under part A of the new title XXI) will determine eligibility for medical assistance in any or all cases under a State's plan approved under title XIX. A State, under such agreement, must pay one half the cost of carrying out the agreement with respect to individuals who are not eligible for benefits under the new title XX or XXI with respect to individuals eligible for benefits under parts A and B of title XXI and under title XX, it would pay only those costs which are additional to carrying out such parts and such title.

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SECTION 506. ASSISTANT SECRETARY OF LABOR FOR THE OPPORTUNITIES FOR FAMILIES PROGRAM

Section 506(a) of the bill provides for the creation of a new Assistant Secretary of Labor to be appointed by the President by and with the advice and consent of the Senate. The new Assistant Secretary is to be responsible for the operation of the Opportunities for Families Program under part A of the new title XXI.

Section 506(b) of the bill makes technical and conforming amendments.

SECTION 507. TRANSITIONAL ADMINISTRATIVE PROVISIONS

Section 507 of the bill provides that, for any State to be eligible for any Federal payments under title IV, V, XVI, or XIX of the Act for any quarter in the fiscal year ending June 30, 1973, such State must enter into agreements with the Secretary of Health, Education, and Welfare and the Secretary of Labor under which the State agencies responsible under present law for administering or supervising the ***5351** administration of the Federal-State programs of assistance to the aged, the blind, the permanently and totally disabled, and aid to families with dependent children (the plans approved under titles I, X, XIV, and XVI, and part A of title IV, of the Act) will administer, on behalf of the Secretaries, all or such part or parts of the Federal assistance programs for adults and for families with children under the new titles XX and XXI, during all or any part of the fiscal year 1973, as may be provided under the agreements. A State could not be made responsible for administering the manpower services, training, employment, and child care provisions of the new title XXI program, and no such agreement could apply in the administration of such program with respect to the working poor-- that is, any family in which both parents are present, neither parent is incapacitated, and the male parent is employed.

SECTION 508. CHILD CARE SERVICES FOR AFDC RECIPIENTS DURING TRANSITIONAL PERIOD

Section 508 of the bill authorizes the Secretary of Health, Education, and Welfare to provide for furnishing child care services for those entitled to receive, them under part A of, title, IV of the Act, and who need such services in order to accept work or participate in a work incentive program, during the period ending June 30, 1972 (the expiration date for AFDC).

PART B-NEW SOCIAL SERVICES PROVISIONS

SECTION 511. DEFINITION OF SERVICES

Section 511(a) of the bill amends section 405(d) of the Social Security Act (as amended by section 402(k) of the bill) to define ‘services for any individual receiving assistance to needy families with children‘ to include (1) family planning services, including medical services, (2) child care services, (3) services to unmarried girls, who are pregnant or already have children, (4) protective services, (5) homemaker services, (6) nutrition services, (7) educational services, (8) emergency services, (9) services to assist family members to engage in training or secure or retain employment, (10) assistance in locating suitable housing and in home management and maintenance, (11) services to drug addicts and alcoholics, and (12) information and referral services to those in need of services from other agencies.

Section 511(b) of the bill amends section 1605 of the Act to define ‘services to the aged, blind, or disabled‘ to include (1) protective services, (2) homemaker services, (3) nutrition services, (4) assistance in locating suitable housing and in home management and maintenance, (5) emergency services, (6) services, including child care, to assist individuals to engage in training or secure or retain employment, (7) services to alcoholics and drug addicts, and (8) information and referral services to those in need of services from other agencies.

SECTION 512. AUTHORIZATION AND ALLOTMENT OF APPROPRIATIONS FOR SERVICES

Section 512 of the bill amends title XI of the Social Security Act by adding a new section 1125 to provide a ceiling on amounts to be appropriated ***5352** for services, and to provide a formula for determining allotments to States from amounts so appropriated.

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The new section 1125(a) limits the appropriations which may be made for services (other than family planning services and child care services) to $800,000,000 for the fiscal year ending June 30, 1973, and to such sums as the Congress may specify thereafter.

The new section 1125(b)(1) provides that the amounts appropriated are to be initially distributed to the States in accordance with the following formula:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

For this purpose (1) ‘allotment‘ is the current Federal allotment to a State; (2) ‘total appropriation‘ is the total amount of the Federal appropriation for the fiscal year; (3) ‘Federal share to State‘ is the Federal share of a State’s expenditures in the preceding fiscal year, excluding amounts reallotted to the State under the new section 1125(c); and (4) ‘total of Federal shares‘ is the total of Federal shares to all States in the preceding fiscal year.

The new section 1125(b)(2) provides for an additional allotment to a State from any sums remaining (up to $50 million) from the initial allotment, if such State has a service deficit.

The term ‘service deficit‘ is defined as the amount by which the average service expenditure per beneficiary in a State is less than the average of expenditures for services and training under titles I, X, XIV and XVI, and part A of title IV (excluding child care and family planning), multiplied by the number of beneficiaries in such State.

The new section 1125(b)(3) provides for the allotment of any sums remaining after the application of the new section 1125(b)(1) and (b)(2).

The new section 1125(c) provides that where the Secretary determines that an allotment to a State for training and services under part A of title IV or under title XVI will not be required, he may reallot such sums to other States in need of them for use in carrying out the same purposes for which the sums were originally intended.

The new section 1125(d) defines the term ‘average service expenditure‘ as the amount obtained by dividing the Federal share of expenditures in a State for the preceding fiscal year (excluding reallotted amounts) by the number of beneficiaries in such State.

SECTION 513. ADOPTION AND FOSTER CARE SERVICES UNDER CHILD-WELFARE SERVICES PROGRAM

Section 513 of the bill amends part B of title IV of the Social Security Act by adding (effective July 1, 1971) a new section 427, relating to adoption and foster care services.

The new section 427(a) defines foster care services as payments for foster care of any child for whom a public agency has responsibility, made to any agency, institution, or person providing such care (but only if such foster care meets standards prescribed by the Secretary), and services and administrative activities related to the foster care of children. Medical care is also included under certain conditions. Adoption services means services and administrative activities related to adoptions and payments (subject to limitations prescribed by the Secretary) to a person or persons adopting a child who is physically or mentally handicapped.

***5353** The new section 427(b) provides that where a State qualifies for Federal funds for child-welfare services there will be 75-percent Federal matching for funds expended by such State for adoption or foster care services.

The new section 427(c) authorizes appropriations, in addition to those authorized for child-welfare services, for adoption and foster care services as follows: $150,000,000 for the fiscal year ending June 20, 1972; $165,000,000 for the fiscal year ending June 30, 1973; $180,000,000 for the fiscal year ending June 30, 1974; $200,000,000 for the fiscal year ending June 30, 1975; and $220,000,000 for the fiscal year ending June 30, 1976, and subsequent fiscal years.

The new section 427(d) provides that, from the sum appropriated pursuant to section 427(c) for any fiscal year, there is to be allotted to each State an amount which bears the same ratio to such sum as the number of children under age 21 in such State bears to the number of such children in all the States.

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SECTION 514. CONFORMING AMENDMENTS TO TITLE XVI AND PART A OF TITLE IV OF THE SOCIAL SECURITY ACT

Section 514 of the bill amends title XVI, and part A of title IX, of the Social Security Act, to make various provisions of such title and such part subject to the authorization and allotment requirements of the new section 1125 of such Act (discussed above), and otherwise to reflect and conform to the changes affecting social services which are made by this part of the bill.

PART C-PUBLIC ASSISTANCE AMENDMENT EFFECTIVE IMMEDIATELY

Part C of title V of the bill makes various amendments to the existing programs of aid and assistance in the Social Security Act, effective during the period beginning on date of enactment and ending with the repeal of those programs on July 1, 1972 (when the new Federal programs go into effect).

SECTION 521. ADDITIONAL REMEDIES FOR STATE NONCOMPLIANCE

Section 521 of the bill adds subsections (e) through (g) to section 1116 of the Act, which relates to administrative and judicial review of certain administrative determinations.

The new section 1116(e) provides that where the Secretary finds that a State has made incorrect payments in a substantial number of cases under title I, X, XIV, XVI, or XIX, or part A of title IV, of the Act, the State may be required to correct the payment errors retroactively. These corrections will not be required for any period prior to the date of enactment of the bill, and the additional payments will be considered as made under an approved State plan for purposes of Federal matching but are not to be counted by the State in determining the amount of future aid or assistance payments.

The new section 1116(f) provides that where the Secretary finds that there is a failure to comply with the procedures of title I, X, XIV, XVI, or XIX, or part A of title IV, with respect to the administration of an approved State plan, he may prescribe administrative methods to correct noncompliance. If the Secretary is satisfied that his recommended methods (including a timetable for implementation) will be ***5354** undertaken, he may continue to make payments to the State for so long as the timetable is being substantially followed.

The new section 1116(g) provides that if the Secretary determines that an approved State plan no longer complies with all the requirements of title I, X, XIV, XVI, or XIX, or part A of title IV, or that there is substantial failure to meet administrative requirements, he may request the Attorney General to bring suit to enforce such requirements in addition to or instead of withholding payments.

SECTION 522. STATEWIDENESS NOT REQUIRED FOR SERVICES

Section 522 of the bill amends sections 2(a), 402(a), 1002(a), 1402(a), and 1602(a) of the Social Security Act to provide that (effective upon enactment) the Secretary may make exceptions to the requirement that with respect to social services State plans must be in effect in all political subdivisions of the State.

SECTION 523. OPTIONAL MODIFICATION IN DISREGARDING OF INCOME UNDER STATE PLANS FOR AID TO FAMILIES WITH DEPENDENT CHILDREN

Section 523 of the bill adds a new subsection (d) to section 402 of the Act, effective upon enactment. The new subsection provides that a State may modify its approved AFDC plan with respect to the earned income disregard for families with a dependent child who is not a student. Such modification could provide that (1) work related expenses will not be excluded from total income, (2) the first $60 of total earned income, plus one-third of the remainder will be disregarded for each month, and (3) child care expenses will be disregarded. The total amount of the earned income plus child care expenses to be disregarded could not exceed $2,000 plus $200 for each family member in excess of four up to a maximum of $3,000.

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SECTION 524. INDIVIDUAL PROGRAMS FOR FAMILY SERVICES NOT REQUIRED

Section 524 of the bill amends section 402(a)(14) of the Social Security Act (effective upon enactment or at a later date (not after July 1, 1972) specified in the State's plan) to eliminate the requirement that a separate service program be developed for each child and relative receiving aid to families with dependent children.

SECTION 525. ENFORCEMENT OF SUPPORT ORDERS AGAINST CERTAIN SPOUSES OF PARENTS OF DEPENDENT CHILDREN

Section 525 of the bill amends section 402(a)(17) of the Social Security Act (effective upon enactment or at a later date (not after July 1, 1972) specified in the State's plan) by adding a new clause (iii) which provides for the securing of support for a parent who has been abandoned or deserted by his or her spouse. Efforts in this regard include obtaining or enforcing court orders for support through use of reciprocal arrangements between the States. Other pertinent provisions are amended to conform to this new provision.

***5355** SECTION 526. SEPARATION OF SOCIAL SERVICES AND CASH ASSISTANCE PAYMENTS

Section 526 of the bill amends title XI of the Social Security Act by adding a new section 1125 to provide that each State must develop and submit a proposal under which the State staff providing social services will be located in organizational units separate from assistance payment units up to the administrative level prescribed by the Secretary. The Secretary may authorize exceptions where he finds it not administratively feasible to separate these functions.

SECTION 527. INCREASE in REIMBURSEMENT TO STATES FOR COSTS OF ESTABLISHING PATERNITY AND LOCATING AND SECURING SUPPORT FROM PARENTS

Section 527 of the bill amends section 403(a)(3)(A) of the Social Security Act (as amended by section 402 of the bill) to increase to 75 percent the rate of Federal matching of the costs of carrying out the requirements of clauses (17), (18), (21), and (22) of section 402(a) of the Act. These requirements include establishing paternity in the case of children born out of wedlock, securing support for any child receiving assistance who has been deserted or abandoned by his parent, and securing support for such parent who has been deserted or abandoned by his or her spouse; entering into cooperative arrangements with appropriate courts and law officials to carry out these requirements; reporting of information to the Secretary to locate a parent of a dependent child receiving aid against whom a support order has been issued but who is not making payments in compliance with the order; and locating and securing compliance by a parent residing in the State against whom a petition has been filed in, and a court order issued by, another State for the support and maintenance of such a child.

SECTION 528. REDUCTION OF REQUIRED STATE SHARE UNDER EXISTING WORK INCENTIVE PROGRAM

Section 528 of the bill amends section 406(b) of the Social Security Act (effective with respect to costs incurred after June 1971) to reduce from 20 to 10 percent the share of expenses under the existing work incentive program which a State is required to contribute.

SECTION 529. PAYMENT UNDER AFDC PROGRAM FOR NONRECURRING SPECIAL NEEDS

Section 529 of the bill amends section 406(b) of the Social Security Act (effective upon enactment) to permit vendor payments under the AFDC program to meet a family's nonrecurring special needs (as defined by the Secretary) which involve a cost of $50 or more.

***5356** PART D-LIBERALIZATION OF INCOME TAX TREATMENT OF CHILD CARE EXPENSES AND

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RETIREMENT INCOME

SECTION 531. Liberalization OF CHILD CARE DEDUCTION

(a) Increase in dollar limits

Subsection (a) of section 631 of the bill amends paragraph (1) of section 214(b) of the Internal Revenue Code of 1954 (relating to expenses for care of certain dependents). Under existing section 214(b)(1) the deduction cannot exceed $600 for any taxable year, except that this $600 amount is increased (to an amount not above $900) by the amount of expenses incurred by the taxpayer for any period during which the taxpayer has 2 or more dependents.

Under the amendment contained in section 531(a) of the bill, the dollar limit, will be $750 for the taxable year, increased (to an amount not above $1,125) by the amount of expenses incurred by the taxpayer for any period during which he or she has 2 dependents, and increased (to an amount not above $1,500) by the amount of expenses incurred while he or she has 3 or more dependents.

This may be illustrated by the following example: A and B, a married couple who file a joint return on a calendar year basis, have 3 adopted children. One child C is 9 years of age, the second child D attained the age of 13 on February 1, and the third child E attained the age of 13 on April 1. A. and B's adjusted gross income for the year is $11,000. During January A and B incurred $250 of expenses for the care of C, D, and E. During February and March, they incurred $400 of expenses for the care of C and E, and for the remainder of the year they incurred $900 of expenses for the care of C. A and B's deduction for the taxable year is $1,375; $750 of the $900 of expenses for the period they had one dependent $375 ($1,125 minus $750) of the $400 of expenses for the period they had two dependents, and the $250 of expenses for the period they had 3 dependents.

(b) Liberalization of income test for working wives and husbands with incapacitated wives

Section 214(b)(1) of the 1954 Code now provides that in the case of a woman who is married (other than one whose husband is incapable of self-support), and in the case of a husband whose wife is incapacitated (other than an institutionalized wife), the child care deduction will be allowed only if a joint return is filed, and then the child care deduction is reduced dollar for dollar by the amount by which the adjusted gross income of the couple exceeds $6,000.

Subsection (b) of section 531 of the bill increases this amount from $6,000 to $12,000. Thus, under this amendment, the working wives and the husbands of incapacitated wives specified above will continue to have to file joint returns to qualify for the childcare deduction, and their deduction will be reduced by one dollar for each dollar that their combined adjusted gross income exceeds $12,000.

(c) Effective date

Subsection (c) of section 531 of the bill provides that the amendments made by section 531 are to apply to taxable years beginning after December 31, 1971.

***5357** SECTION 532. LIBERALIZATION OF RETIREMENT INCOME CREDIT

In general

Subsection (a) of section 632 of the bill amends section 37 (relating to retirement income credit) of the Internal Revenue Code of 1954. These changes will be effective for taxable years beginning after December 31, 1971.

SECTION 37. CREDIT FOR THE ELDERLY

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(a) General rule

Section 37(a) of the Code (as amended by sec. 532(a) of the bill) provides (1) that an individual who is 65 years or older on the last day of the taxable year or (2) that an individual who has not reached age 65 by the last day of the taxable year, but who has public retirement system pension income for the taxable year, is allowed a credit against the tax imposed by chapter 1 of the Code. This credit is an amount equal to 15 percent of the individual's section 37 amount (as defined in sec. 37(b)) for the taxable year but may not exceed the individual's tax under chapter 1 for the year.

(b) Section 37 amount

Section 37(b) provides rules for determining an individual's section 37 amount.

(1) In general

Paragraph (1) of section 37 provides that for purposes of subsection (a) of section 37 an individual's section 37 amount is the individual's applicable initial amount as determined under paragraph (2) of section 37(b) reduced as provided in paragraph (3) of section 37(b).

(2) Initial amount

Paragraph (2) of section 37(b) provides rules for determining an individual's initial amount. Under section 37(b)(2) the initial amount is $2,500 in the case of a single individual eligible for the credit under section 37(a), $2,500 in the case of a joint return where only one spouse is eligible for the credit, $3,750 in the case of a joint return where both spouses are eligible for the credit, or $1,875 in the case of a separate return by a married individual who is eligible for the credit.

(3) Reduction

Paragraph (3) of section 37(b) provides (except as provided in paragraphs (4) and (5)(b)) rules for determining the amount of an individual's reduction for purposes of computing his section 37 amount.

Subparagraph (A) of section 37(b)(3) provides that an individual's initial amount is to be reduced by the amount of any pension or annuity received during the year under title II of the Social Security Act or the Railroad Retirement Act of 1935 or 1937, and by the amount of any pension or annuity otherwise exempt from taxation.

Subparagraph (B) of section 27(b)(3) provides, in the case of any individual who has not attained age 72 before the close of the taxable year, for a reduction (in addition to the reduction provided for in subparagraph (A)) for earned income in excess of certain amounts. Except in the case of certain individuals receiving public retirement system pension income, the initial amount is to be reduced further by ***5358** one-half of the excess of earned income received by such individual over $2,000. If an individual has not attained age 62 before the close of the taxable year, and if such individual or his spouse who has not attained age 62 by the close of the taxable year is eligible for the credit under section 37 because of the receipt of public retirement system pension income, the initial amount is to be reduced further by the excess of earned income over $1,000. Thus, for example, if a husband and wife (both under age 62 on the last day of the taxable year) file a joint return where only the husband has received public retirement system pension income during the taxable year each spouse bases the reduction upon the amount of that spouse's earned income in excess of $1,000. However, if the husband is age 75 and the wife is age 50 and is not eligible for a credit by reason of section 37(a)(2), the reduction in the case of the wife is based upon her earned income in excess of $2,000, and there would be no reduction with respect to the earned income of her husband.

(4) Special rules for determining the reduction provided in paragraph (3)

Paragraph (4) of section 37(b) provides special rules for determining the reduction in the case of married individuals and in the case of certain exempt income.

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Joint return

Subparagraph (A) of section 37(b)(4) provides that in the case of a joint return the reduction under paragraph (3) of section 37(b) is the aggregate of the amounts resulting from applying paragraph (3) separately to each spouse.

Separate returns of married individuals

Subparagraph (B) of section 37(b)(4) provides that if a married individual files a separate return the rules for reductions for earned income are modified. In such a case, (1) if a married taxpayer is 62 years of age or over (but under 72), there is a reduction on his separate return for one-half his earned income in excess of $1,000, or (2) if he is under 62 years of age, there is a reduction on his separate return for the excess of his earned income over $500.

The application of subparagraphs (A) and (B) of section 37(b)(4) is illustrated by the following examples:

Example (1).-- Assume that A is 74, and that his wife B is 66 years of age. During 1972 A receives earned income of $3,000 and B receives earned income of $4,000. If A and B file a joint return for taxable year 1972, there would be a reduction of $1,000 for earned income-- no reduction for the earned income of A since he is not under 72 years of age and $1,000 (one-half of the excess of $4,000 over $2,000) in the case of B. If A and B file separate returns for the taxable year, A would make no reduction for earned income on his return since he is not under 72 years of age while B would have a $1,500 reduction for earned income on her return, because, as a married person filing a separate return, B reduces her initial amount by one-half the excess of $4,000 (earned income) over $1,000 (under the special rule of sec. 37(b)(4)(B)).

Example (2).-- Assume that C is 66 and that his wife D is 61 years of age. During 1972 each receives earned income of $2,000. D receives $5,000 of public retirement system income during the year. If C and D filed a joint return for taxable year 1972, there would be a reduction of $2,500 for earned income, that is the sum of (1) $500, one-half of C's earnings in excess of $2,000, and (2) $2,000, all of D's earnings in ***5359** excess of $1,000. If C and D filed separate returns for the taxable year C would have a reduction for earned income of $1,000, one-half of earned income in excess of $1,000. D, on her separate return, would have a reduction of $2,500, all of her income in excess of $500.

No reduction for certain amounts excluded from gross income

Subparagraph (C) of section 37(b)(4) provides that no reduction (under sec. 37(b)(3)(A) is to be made for amounts received as pensions and annuities which are excluded from gross income under section 72 (relating to annuities), 101 (relating to compensation for injuries or sickness), 105 (relating to amounts received under accident and health plans), 402 (relating to taxability of beneficiary of employees' trust), or 403 (relating to taxation of employees annuities) of the 1954 Code.

(5) Special rules for individual eligible under subsection (a)(2)

Paragraph (5) of section 37(b) provides special rules for cases where an individual qualifies for the credit for the elderly under section 37(a)(2) by reason of public retirement system income.

Limitation to public retirement system income

Subparagraph (A) of section 37(b)(5) provides that, except as provided in subparagraph (B) of section 37(b)(5), the section 37 amount of an individual who qualifies for the credit for the elderly under section 37(a)(2) by reason of receipt of public retirement system income is not to exceed such individual's public retirement system income.

Rule where one spouse a public retiree and the other 65 or over

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Subparagraph (B) of section 37(b)(5) provides for a reduction (in addition to those set forth in sec. 37(b)(3) where one spouse qualifies for the credit for the elderly under section 37(a)(1) (i.e., where such spouse is 65 or over) and the other spouse qualifies under section 37(a)(2) (i.e., where such spouse is under 65 but received public retirement system income). In such a case, subparagraph (A) of section 37(b)(5) does not apply and there is an additional reduction under paragraph (3) of section 37(b) in an amount equal to the excess (if any) of $1,250 over the amount of public retirement system income received during the taxable year by the spouse who is eligible as a public retiree.

The application of paragraph (5) of section 37(b) is illustrated by the following examples:

Example (1).-- Assume that A and his wife B are each 60 years of age. During 1972, A and B each receive $1,300 of public retirement system income. Neither receives earned income or any other amounts described in section 37(b)(2) during the year. A and B file a joint return for taxable year 1972 and accordingly their initial amount under section 37(b)(2)(C) of $3,750 is not reduced by any reduction described in section 3(b)(3). Their section 37 amount for 1972 would be $2,600, however, because under section 37(b)(5)(A) such section 37 amount cannot exceed public retirement system income for the year.

Example (2).-- Assume that C is 66, and that his wife D is 61 years of age. During 1972, C receives $2,000 of earned income, and D receives $500 of public retirement system income. D does not receive any earned income for 1972. For such year, neither receives amounts described in section 37(b)(3)(A) (Social Security, etc.). C and D file a joint return for the taxable year. The section 37 amount with respect ***5360** to such return would be $3,000, $2,750 less $750 (the excess of $1,250 over D's public retirement system income ($500)).

(c) Definitions and special rules

Subsection (c) of section 37 contains definitions and special rules applicable to section 37.

(1) Earned income

Paragraph (1) of section 37(c) provides that the term 'earned income', for purposes of section 37, has the meaning assigned such term in section 911(b) of the Code, but that such term does not include any amount received as a pension or annuity. Paragraph (1) also provides that community property laws are not to be taken into account in determining whether earned income is the earned income of the husband or of the wife.

(2) Marital status

Paragraph (2) of section 37(c) provides that, for purposes of section 37, marital status is to be determined under section 153 of the Code.

(3) Joint return

Paragraph (3) of section 37(c) provides that the term 'joint return' means the joint return of a husband and wife made under section 6013 of the Code.

(4) Public retirement system pension income

Paragraph (4) of section 37(c) provides that public retirement system pension income is income from pensions and annuities under a public retirement system which is received for ther performance of personal services by the individual or his spouse, to the extent included in gross income without reference to section 37, but that such term does not include compensation for personal services rendered during the taxable year. A 'public retirement system' is a pension, annuity, retirement, or similar fund established by the United States, a State, a possession of the United States, a political subdivision of any of the foregoing, or the District of Columbia. Under paragraph (4) the amount of public retirement system pension income taken

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into account with respect to any individual may not exceed $2,500.

The application of paragraph (4) of section 37(c) is illustrated by the following example:

Example.-- Assume that A and his wife B are 60 years of age. During 1972, A receives $3,000, and B $500, of public retirement system pension income. Neither has earned income or amounts described in section 37(b)(3)(A) (Social Security, etc.) for the year. A and B file a joint return for taxable year 1972. The section 37 amount of A and B for 1972 is $3,000 because no more than $2,500 of A's public retirement system pension income is taken into account.

(d) Nonresident alien ineligible for credit

Subsection (d) of section 37 provides that the credit for the elderly is not to be allowed to any nonresident alien.

Sec. 532. (Continued) (b) Technical amendments

Subsection (b) of section 532 of the bill makes certain technical amendments to the Code.

(1) Foreign tax credit

Subsection (b) (1) of section 532 of the bill amends section 904 of the Code (relating to limitation on foreign tax credit). Under ***5361** existing law the retirement income credit allowed by section 37 is allowed only to the extent of the tax for the taxable year under chapter 1 of the Code reduced by the foreign tax credit allowable for the year under section 901 (a) of the Code and certain other allowable credits against tax. The amendment made by this subsection of the bill redesignates subsection (g) of section 904 as subsection (h) and adds a new subsection (g) to section 904 of the Code. New subsection (g) provides, in the case of an individual, that for purposes of computing the limitation of the foreign tax credit, the tax against which the foreign tax credit is taken under section 904 (a) is such tax reduced by the amount of any credit allowable under section 37.

(2) Tax not computed by taxpayer

Paragraphs (2) and (3) of subsection (b) of section 532 of the bill amend section 6014 of the Code (relating to tax not computed by the taxpayer) to make it clear that the credit for the elderly will be available to taxpayers who elect to have the Secretary of the Treasury or his delegate compute the tax and who comply with the regulations prescribed under section 6014(b).

(3) Conforming amendments

Paragraphs (4) and (5) of subsection (b) of section 532 of the bill make clerical changes.

(c) Effective date

Subsection (c) of section 532 of the bill provides that the amendments made by section 532 are to apply to taxable years beginning after December 31, 1971.

PART E-MISCELLANEOUS CONFORMING AMENDMENTS

SECTION 541. CONFORMING AMENDMENT TO SECTION 228(d)

Section 541 of the bill makes conforming changes in section 228(d)(1) of the Social Security Act, which precludes benefits

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under section 228 (benefits at age 72 for certain uninsured individuals) for individuals receiving cash benefits under public assistance programs.

SECTION 542. CONFORMING AMENDMENTS TO TITLE XI

Section 542 of the bill makes various changes in title XI of the Social Security Act (general provisions) to reflect the repeal of the existing cash assistance programs by sections 302, 303, and 402 of the bill and to conform to the new Federal programs (titles XX and XXI) established by sections 301 and 401 of the bill.

SECTION 543. CONFORMING AMENDMENTS TO TITLE XVIII

Section 543 of the bill amends title XVIII of the Social Security Act by eliminating all references to money payments under titles I, X, XIV, XVI, and IV in section 1843, which relates to State agreements for 'buying in ' coverage of eligible individuals who are receiving money payments under public assistance programs (or are eligible for medical assistance), and by continuing wn effect the State buy-in agreements covering individuals eligible for medicaid under title XIX.

***5362** Section 543(a) of the bill amends section 1843 of the Act by replacing the present subsections (a) and (b) with two new subsections.

The new section 1843(a) requires the Secretary, at the request of any of the States to continue in effect (notwithstanding the repeal of the existing Federal-State programs providing cash assistance to needy persons) the existing 'buy-in' agreements under which the States pay supplementary medical insurance premiums on behalf of individuals eligible both for medical insurance and for medical assistance under the State plans approved under title XIX of the Act. Any such agreement, insofar as it pertains to recipients of money payments under the State plan, would be deemed to pertain, at the option of the State, to individuals or family members described in section 1902(e) of the Act (as added by section 209(d) of the bill) or to individuals who are eligible to receive benefits under title XX or title XXI. Such agreements will also, at the request of any State, be continued with respect to individuals otherwise eligible for medical assistance under the State plan approved under title XIX, and will be deemed to include individuals made eligible for supplementary medical insurance by section 201 of the bill.

The new section 1843(b) provides that section 1843(h)(2) (relating to the beginning and ending of the coverage period of certain individuals eligible for supplementary medical insurance by section 201 of the bill.

The new section 1843(b) provides that section 1843(h)(2) (relating to the beginning and ending of the coverage period of certain individuals eligible for medical assistance) will continue to apply to individuals included in a state agreement after the effective date of the repeal of (or amendments to) the cash assistance titles of the Act which are provided for by the bill.

Section 543(b) of the bill amends section 1843(c) of the Act to delete an obsolete reference to the former section 1843(b).

Section 543(c) and (d) of the bill amend sections 1843(d)(3) and 1843(f) of the Act to eliminate references made obsolete by the elimination of the Federal-State cash assistance programs.

Section 543(e) of the bill strikes out subsections (g) and (h) of section 1843 of the Act, which relate to modifications of State agreements under section 1843 that under existing law may no longer be made.

SECTION 544. CONFORMING AMENDMENTS TO TITLE XIX

Section 544 of the bill amends various provisions of title XIX of the Social Security Act (grants to States for medical assistance programs) to reflect the repeal of the existing cash assistance programs by sections 302, 303, and 402 of the bill and to conform to the new Federal programs (titles XX and XXI) established by sections 301 and 401 of the bill.

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VI. ADDITIONAL VIEWS OF HON. HUGH L. CAREY, HON. CHARLES A VANIK, HON. WILLIAM J. GREEN, AND HON. JAMES C. CORMAN on H.R. 1

Although we voted to report out H.R. 1 and we intend to support and vote for its passage, we would like to express certain reservations with respect to the impact of some of its provisions on the poor and the elderly. Among them are the establishment of an annual income $2400 for a family of four which is far too low for the poor who live in the cities of the North and West, and the failure to provide adequate ***5363** financial relief for the states which have been making the greatest financial effort in behalf of the poor.

SOCIAL SECURITY, MEDICARE, MEDICAID

H.R. 1 in its final form does make far-reaching and needed improvements in the Social Security cash benefits program as well as in the Medicare, Medicaid and maternal and child health programs. An important provision is the 5 percent across-the-board increase in Social Security payments for all beneficiaries, effective June 1972. The 5 percent benefit increase is desperately needed to maintain their level of income.

Yet, even in these programs, certain provisions now in the law which we think should have been changed were not changed, and several amendments have been adopted which have the effect of restricting certain benefits to the poor and the indigent.

The provision for increasing the minimum monthly benefits under the Social Security Act to as much as $150 for an individual with thirty years of coverage and $225 if he has a wife is long overdue. This change will go a long way toward eliminating from the old age assistance rolls, which are financed out of general revenue money, many Social Security beneficiaries. Yet the cost of this change is to be paid out of Social Security contributions the burden of which falls most heavily upon low-wage earners. We would have favored a provision to pay part of such costs out of general revenue.

In Medicare the same pattern is followed. The inclusion in the Medicaid program of disabled recipients of cash benefits under the Social Security and railroad retirement programs will extend health insurance protection to about 2 million persons. However, hospitalized persons must now pay for part of the hospital costs during the 31st day to 60th day of hospital confinement. This provision may place additional burdens on persons when they are least able to pay. Fortunately, as indicated in the report, the Committee bill does use these savings to extend the lifetime reserve.

While the provisions relating to health maintenance organizations are aimed at encouraging the provision of more comprehensive care, at the same time, the Committee seeks to repeal the current statutory requirement that States move toward comprehensive Medicaid programs Provisions permitting states to reduce the scope of Medicaid benefits, to require premium payments and impose cash deductibles on the medically indigent, will result in their exclusion from benefits or the transfer of the cost of their medical care to the already financially burdened cities and states.

The medical benefits of the poor and indigent should not be contracted through federal legislation or their burdens transferred to the states in an attempt to restrain the increasing costs of the program to the federal government.

FAMILY ASSISTANCE

Our most serious reservations, however, are with some of the provisions of Title IV of HR 1 which would replace the present program of Aid to Families with Dependent Children with the new ‘Opportunities for Families Program and Family Assistance Plan.‘

***5364** Title IV does take several significant steps towards the establishment of a sound welfare system:

(1) it establishes a federally financed floor of assistance which will at least raise benefits in a few states that now pay the least.

(2) It provides incentives for families to work and includes in the universal program all families including those with a full-time working father in the home.

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(3) It provides uniform eligibility rules for entitlement to the Federal Benefit and federal administration of the program.

(4) It creates an extensive program of federally administered and financed child care, training, manpower and other services to enable recipients to secure jobs. It creates a program of public service employment to provide needed jobs for some recipients although the number of jobs is not sufficient and the requirement for partial state financing is objectionable.

Recognition of these significant forward steps should not, however, blind us to the weakness and inadequacies which have been incorporated in the new program.

BENEFIT LEVELS

The minimum payment levels are clearly insufficient to provide a family with sufficient income to meet its minimal needs. This insufficiency is more serious since states are not required to maintain present benefit levels. For a family of four, $2400 is more than $1500 below the official poverty line established by the Department of Health, Education and Welfare. It is no more than the $2400 that the Ways and Means Committee itself considered necessary as a minimum payment to support an aged, blind or disabled family of two persons.

Proposals to raise the $2400 were rejected by the Committee on the grounds of additional costs and that a benefit adequate for a family in high cost metropolitan areas of the north would have an adverse impact on low cost rural areas in the south. To meet the argument that increased benefits would result in an increase in the current federal deficit, proposals were made to establish a goal of adequacy towards which the benefit would be increased over a fixed period of years; and in recognition of the varying economic conditions within the United States to adjust the minimum benefit level to meet the increased cost of food and other shelter items in high cost areas. Yet these proposals were defeated.

The $2400 level must also be considered in relation to the provision of the bill making welfare recipients ineligible for food stamps. While we support the cash out of food stamps and the establishment of a single integrated system of providing cash to needy families, it must be recognized that if the objectives are to be accomplished states must supplement their current welfare payments with the cash value of the food stamps. Unless they do so, the poor and the needy in most states will pay for the efficiencies and cost savings to the federal government resulting from the elimination of food stamps.

Unfortunately the Committee rejected provisions to assure that no recipient would be worse off than under existing law-- a cardinal principle which the President stated in August 1969, when he first proposed the Family Assistance Program to the nation. The Committee even eliminated from HR1, as introduced in the Congress, specific provisions which it has passed last year requiring states to maintain their current payment levels.

***5365** While the Committee assured to the states that they could protect persons from loss of benefits maintaining current benefit levels and increasing them by the value of food stamps without having to expend more in welfare funds in future years than they spent in calendar year 1971, such provisions will not protect beneficiaries in all states. Some states may seize the opportunity which this will give them to escape from all welfare costs by reducing their payment down to $2400.

If financial incentives through the offer of fiscal relief to states is to be instrumental in assuring benefit protection to individuals, two elements are essential. First, the fiscal relief must be contingent on state action to provide protection to needy families by assuring that present benefits not be reduced. Second, the fiscal relief must be sufficient to affect all states. It was for this reason that we proposed a hold harmless clause which would have provided that those states which increased their current benefit levels by food stamp values would have been protected against expenditures exceeding 75% of their 1971 costs. Our proposal would have given to the states and localities an additional $4.2 billion in fiscal relief during the five-year period. And it would have assured that a fair share of fiscal relief would have gone to those states which have undertaken the greatest financial burdens in providing more adequate welfare benefits.

WORK REQUIREMENTS

While we agree with provisions requiring all welfare recipients who can work to do so and with those provisions for training

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and job creation to assure that they will be able to work, we are opposed to provisions that arbitrarily require all mothers with pre-school age children above three to work as a condition to receipt of benefits. The Committee recognized that such requirement was dependent upon the availability of adequate day care facilities. Yet, with the increases in juvenile delinquency and drug abuse, in some situations, both society and the family would be better served by a recognition that the work of the mother in caring for her children would be more meaningful than requirements which would separate her from vital family obligations.

The provisions adopted by the Committee requiring that jobs offered to welfare recipients must pay at least 75% of the federal minimum wage rate does establish a floor on jobs which will reflect increases in the minimum wage law. Such floor, however, would better be set at the minimum wage level itself. To do less would overlook the significant differential in the cost of living in urban areas. Every effort should be made to avoid providing a captive work force to employers who offer jobs at substandard wages or working conditions.

LEGAL RIGHTS

We are concerned with the provisions which would permit states to reinstitute residence requirements of up to one year. Population stability is assured by equal opportunity for employment and for those in need by a national welfare system paying adequate benefits, rather than through the establishment of interstate barriers to the mobility of the poor in exactly the way which the Supreme Court prohibited in Shapiro vs. Thompson (394 US 618).

***5366** ADMINISTRATION AND JOB PROTECTION FOR WELFARE EMPLOYEES

While we endorse the provisions for federal administration of the cash benefit system of welfare including administration of state supplemental payments, the Committee failed to recognize that such administration would substitute for administration now performed by state and local welfare employees, many of whom are former welfare recipients. It would seem practical and logical that those who are trained be given an opportunity to perform their duties and retain the employment for which they are obviously as qualified as those who the federal government would seek to train in their place. In being transferred, they should be able to retain the benefits obtained through collective bargaining efforts on their behalf.

PUERTO RICO AND OTHER INSULAR AREAS

We recognize that the Committee action moves in the direction of more equitable treatment of the Commonwealth of Puerto Rico and other insular areas. This is evidenced by the change in benefit level for a family of four from $636 to $1320. This figure, however, is considerably below the federal minimum standard of $2400. We recognize that this is an involved and complicated question. We recognize that the relationship between income levels in Puerto Rico and state public assistance benefits presents a problem and that this problem has been negotiated by the Administration AND THE Commonwealth government and those in the Department of Health, Education, and Welfare.

The problem remains that as long as States such as New York, Pennsylvania, Massachusetts, Ohio, etc., have a more attractive level of benefits, there is an incentive to migrate to those areas from the Commonwealth and other insular areas at a time when unemployment is a problem both in the area of origin and in the area of destination. With this in mind, the Department, which is undertaking the administration of the program in insular areas and in the States, should be prepared to accept a new responsibility. The Department should initiate such positive programs as are required to improve opportunities for employment through training and bring about a better system of benefits through work programs than has been in effect heretofore.

It is not our intent to state that any such program be designed to impede or deter citizens from moving freely in search of employment. Rather, we want to make sure that a decision would be made on the grounds of self-improvement; not due to pure economic differential in welfare.

We are pleased the Secretary has agreed, therefore, to implement these programs which would benefit the citizens of Puerto Rico and other insular areas as well as all the other citizens of the United States found to be eligible and in need.

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***5367** CONCLUSION

H.R. 1, if amended to eliminate the defects noted above, would move toward a federally administered and federally financed welfare system which would provide adequate benefits on a fair and equitable basis. We hope when this bill reaches the other body, the amendments we have suggested will be adopted.

Representative HUGH L. CAREY
Representative CHARLES A. VANIK
Representative WILLIAM J. GREEN
Representative JAMES C. CORMAN

VII. ADDITIONAL VIEWS OF HON. SAM M. GIBBONS ON H.R. 1

Last year, when the Ways and Means Committee had the family assistance program under consideration I proposed that we convert food stamp bonuses into equivalent cash payments to be added onto welfare checks. My goal was to simplify the structure of programs for the needy, eliminate duplicative administrative costs, and end the degradation of forcing the poor, and ouly the poor, to use a special form of ‘funny money‘ when they wanted to buy food. At the same time, I wanted to assure that all Americans would have sufficient purchasing power, if they spent their funds wisely, to afford an adequate, nutritious diet.

This year, both the Committee and the Administration have agreed to adopt the core of my proposal. The present bill combines the family assistance and food stamp plans into a single, integrated cash-benefit program.

Under last year’s proposal each eligible needy family of four without outside income would have received $1,600 in cash plus the chance-- and it was merely that-- if the family resided in a county that dispensed food stamps, to go through the additional maze of the food stamp bureaucracy and obtain bonus stamps worth $864 a year. Each needy aged adult would have received $1,320, plus the opportunity to increase his buying power with $120 in bonus stamps.

Under this year’s bill, with the combination program, each such family will receive $2400 to use as it sees fit, among other things, to purchase the food it needs to maintain the well-being of each member. This year the aged adult will obtain $1560, including the cash portion of food stamps.

Last March, only 5 million persons throughout the country were able to secure food stamps. As of this March, some 10.6 million people were participating in the food stamp program. But, shortly after the new program contained in this bill goes into effect (on July 1, 1972 for AFDC families and January 1, 1974 for the working poor), more than 25 million persons could be enjoying the fruits of the food stamp program converted into cash, including 4 million who previously could only get commodities and 10 million-plus who got no food assistance at all. By the simple translation of stamps into cash, the effective reach of our anti-hunger efforts will have more than doubled.

While I am pleased with this result, I am mindful of the fact that its implementation depends, in part, upon the willingness of various ***5368** state legislatures to cooperate with the Congress. They must agree to supplement their current welfare payments with the cash food bonuses. They can take this step at no additional cost whatever to their state budgets over and above what they are now spending on welfare alone. The pattern is as follows:

(1) In Alabama, Arkansas, Louisiana, Mississippi, and South Carolina, no further action would be necessary. The $2400 Federal payment level covers the full value of food stamps there.

(2) In 7 other states in which both the present welfare payment levels and needs standards are equal to or less than $2400 the states would have to agree to add the applicable cash bonus value of food stamps (under food stamp purchase schedules now in effect) to the welfare payment level and offer each recipient the difference between that sum and $2400. In no event would any such state (Maryland, New Mexico, North Carolina, Ohio, Oklahoma, Texas and West Virginia) have to expend more in welfare outlays in 1972 or beyond than it is spending right now. That is the essence of our so-called ‘hold harmless ‘ clause, which encompasses food stamps as well. Furthermore, every state would be rid of the burden of the administrative expense of

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certifying food stamp users and selling stamps.

(3) Finally, in the remaining 38 states and the District of Columbia, there would have to be determinations both to continue to maintain the current welfare payment levels (and/or needs standards) and to augment them by food stamps in the form of cash. Nineteen of those states, once they are committed to not reducing their welfare grants, could also supply the cash value of stamps without losing a penny of the savings they can anticipate under this bill. The rest, including the District of Columbia (which means that the Congress will have to make the decision), could hold firm to current welfare payment levels, superimpose food stamps as well and still not have to budget more funds for welfare than at present. They would have to forego some potential savings, ranging from as much as $166 million in the case of California to as little as $1 million for Wyoming. According to HEW projections, they would still save substantial sums-- for example, $140 million in California and $165 million in my own state of Florida. No state-- I repeat-- no state would be required to spend any extra sum to accomplish the complete cashing-out of food stamps for all of its needy citizens.

Thus, it is my believe that the objective I sought last March will finally be achieved a little over a year from now if state legislatures fulfill their responsibility as Congress has shouldered its. The results, from the point of view of the hard-pressed poor and hard-pressed state budgets, can only be highly favorable.

There admittedly remains a rather minor problem of the residual food stamp programs for persons ineligible for assistance under this bill-- needy single individuals between the ages of 18 and 65 who are neither blind or disabled, needy couples without children who are neither blind nor disabled and those other persons who meet the slightly different eligibility requirements of the food stamp program, but not those of this program. Such persons number considerably less than 3 million. This issue should be disposed of in the future, preferably by extending the provision of cash to these groups and replacing their stamps with money. Food stamps have survived on and off as a program to feed the poor since 1939. They have outlived their usefulness.

***5369** VIII. DISSENTING VIEW OF HON. AL ULLMAN ON H.R. 1

I fully concur with those provisions of H.R. 1 which will improve benefits and the administration of the Social Security and Medicare/Medicaid programs. I also concur with those provisions that will establish welfare benefits for the aged, blind and disabled under a new, totally federal program.

However, I have strong objections to those provisions of the bill dealing with family welfare programs. In my judgment, these provisions represent an entirely new direction in federal social and economic policy that could very well adversely alter the course of American history.

There is no question in my mind that Title IV of H.R. 1 would take us down the road to a guaranteed annual income. This would be an irreversible step that would put million of Americans permanently on the welfare rolls. The pressures most certainly will build to increase the cash payments under the Title IV provisions, and we will have invented a massive, new ingredient for inflation at a time when our economy is already badly out of kilter. And finally, for the first time in our history we will have opened up the U.S. Treasury to individuals who will be able to file an application and draw on general federal revenues.

What we need is real welfare reform, rather than simply a costly addition to the present disorderly welfare system.

Title IV institutes a whole new set of problems on its cash payments provisions. There will be the impossible administrative complexities of individual payments fluctuating month by month according to varying earned and unearned income, family size and owned assets. There will be the continuing problems of state supplementation as well as the debilitating social and economic effects of state differentials in benefit levels.

Perhaps more importantly, Title IV fails to give proper emphasis to the keystones of welfare reform-- child care, job training and job placement. Without a greatly expanded and closely integrated program of national child care we cannot hope to achieve real welfare reform. This bill deals only in tokenism when it comes to child care, failing even to establish the national independent agency that will be necessary to operate an effective program.

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Title IV calls for a distinction of welfare applications as employable and unemployable but fails to provide ways to make this distinction meaningful. As I have indicated, the child care provisions are inadequate. A woman cannot be considered employable unless she is offered adequate care for her children while she works. The bill also fails to open up new training opportunities of any consequence for employable persons.

The distinction of employable and unemployable becomes totally meaningless when we realize that under the bill persons in both categories will receive the same cash benefits from the federal government.

All this amounts to cynicism of the highest order, and will serve only to raise again expectations that cannot be met.

Within committee, I have offered, in my judgment, a carefully drawn, responsible alternative for welfare reform, H.R. 6004. My program, REACH (Rehabilitation, Employment Assistance and ***5370** Child Care), provides for a new and major national day care program. It provides for priority treatment of employable welfare applicants under greatly expanded federal job training and placement programs. It makes a meaningful distinction between employable and unemployable persons, fully removing employable persons from the welfare system and giving them all the services and incentives necessary to guarantee them a real opportunity to be employed, to maintain their self-respect, and to become fully participating members of society.

I am convinced that Title IV of H.R. 1 is the wrong road for America, that its guaranteed annual income provision is dangerous and irreversible. With it in the bill, I must oppose the entire measure.

AL ULLMAN

1 Hereinafter the first full year, when referring to the effects of changes in the social security cash benefits or medicare programs, refers to the 12 months beginning July 1972.

2 The new credit is eliminated at $7,000 of earnings because at that level one-half of the earnings in excess of $2,000 (one-half of $5,000) equals his $2,500 maximum amount for the credit.

3 Assuming the alternative retirement income credit computation based on $2,286.

4 At $6,520 of earnings (assuming each spouse earned at least $2,000) the earnings in excess of $2,000 for each spouse would be $2,520. One-half of this excess is $1,260. The $3,750 maximum amount reduced by $1,260 is $2,490. The credit of 15 percent of $2,490 offsets the tax on $2,520 of taxable income remaining after the four $750 personal exemptions and the $1,000 minimum standard deduction.

5 If each spouse has at least $2,000 of earnings, the maximum amounts of the credit is reduced $1.00 for each $2.00 of earnings in excess of $4,000. Thus, the credit disappears at twice $3,750 ($7,500), plus $4,000, or $11,500.

6 An example of the type of tax form to be used by taxpayers under age 65 who receive pension income from public retirement systems is shown at the end of the general explanation.

1A One other feature of the credit was adopted in the 1964 Revenue Act. This provision allowed spouses 65 and over who file joint returns to claim a credit on up to $2,286 of retirement income (one and one-half times the $1,524 maximum base for single people) even if one spouse receives the entire amount of the married couple's retirement income.

7 In addition, in the case of a joint return with one spouse age 65 or over and the other under age 65 and receiving public pension income the $3,750 maximum amount for the credit is reduced by $1,250 minus the public pension income received by the younger spouse. In effect, the taxpayer age 65 or over is entitled to the $2,500 available to elderly taxpayers, and in order for the couple to receive the $3,750 maximum, the spouse under age 65 must have at least $1,250 of pension income. Otherwise, the taxpayer age 65 whose spouse did not receive such pension income.

(Note: 1. PORTIONS OF THE SENATE, HOUSE AND CONFERENCE REPORTS, WHICH ARE DUPLICATIVE OR ARE DEEMED TO BE UNNECESSARY TO THE INTERPRETATION OF THE LAWS, ARE OMITTED. OMITTED MATERIAL IS INDICATED BY FIVE ASTERISKS: *****. 2. TO RETRIEVE REPORTS ON A PUBLIC LAW, RUN A TOPIC FIELD SEARCH USING THE PUBLIC LAW NUMBER, e.g., TO(99-495))

H.R. REP. 92-231, H.R. Rep. No. 231, 92ND Cong., 2ND Sess. 1972, 1972 U.S.C.C.A.N. 4989, 1971 WL 11290 (Leg.Hist.)

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