

**AMENDMENTS TO
THE SOCIAL SECURITY ACT
1969 – 1972**

**Social Security Amendments of 1972
(Public Law 92-603)
and Related Amendments**

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**Social Security Amendments of 1970
(H.R. 17550—Not Enacted)**

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Social Security Amendments of 1972 and Related Amendments

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**SOCIAL SECURITY AMENDMENTS
OF 1972**

REPORT

OF THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

TO ACCOMPANY

H.R. 1

**TO AMEND THE SOCIAL SECURITY ACT, AND
FOR OTHER PURPOSES**

(Together With Additional Views)

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

RUSSELL B. LONG, *Chairman*



SEPTEMBER 26 (legislative day, SEPTEMBER 25), 1972

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

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Calendar No. 1175

92D CONGRESS } SENATE } REPORT
2d Session } No. 92-1230

SOCIAL SECURITY AMENDMENTS OF 1972

SEPTEMBER 26 (legislative day, SEPTEMBER 25), 1972.—Ordered to be printed

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

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 1]

The Committee on Finance, to which was referred the bill (H.R. 1) to amend the Social Security Act to increase benefits and improve eligibility and computation methods 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 replace the existing Federal-State public assistance programs with a Federal program of adult assistance and a Federal program of benefits to low-income families with children with incentives and requirements for employment and training to improve the capacity for employment of members of such families, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

I. GENERAL STATEMENT

(1)

I. GENERAL STATEMENT

H.R. 1 represents the most massive revision of the social security laws that the Congress has ever undertaken. When combined with the 20-percent social security benefit increase enacted into law July 1 of this year, the bill would increase Federal expenditures by \$22 billion more than would have been expended under the law in effect before the 20-percent benefit increase was enacted. That increase amounted to an additional \$8 billion in social security benefits; the social security provisions of the committee bill would raise cash benefits another \$3½ billion.

Medicare benefits would rise \$3 billion by 1974, due principally to extension of medicare coverage to the disabled and to the inclusion of drugs among the benefits provided under the program. 22 million medicare beneficiaries, including two million disabled persons, would benefit by the improved protection.

It is estimated that more than 5 million aged, blind, and disabled persons would receive benefits under the new supplemental security income program established under the bill, which would set a Federal minimum guaranteed income at an added cost of \$3 billion in 1974.

But perhaps the most significant features of the bill are those seeking to reform the program of aid to families with dependent children. The committee bill offers a bold new approach to the problem of increasing dependency under this program. Under the committee bill, if the family is headed by a father or if it is headed by a mother whose youngest child has reached school age, the family would not be eligible to receive its basic income from welfare but instead would be given an opportunity to become independent through employment, including a guaranteed job and substantial economic incentives to move into regular jobs. The cost of this new guaranteed job program would be borne entirely by the Federal Government, and its cost together with the substantial increase in Federal funds for the remaining AFDC program would amount to an estimated increase of more than \$4 billion in Federal expenditures in 1974, with more than half of this amount (over \$2 billion) representing increased income to low-income working families.

Aims of Committee Bill

When a bill is as complicated as H.R. 1 and deals with so many complicated issues affecting as many programs as H.R. 1 does, it is difficult to characterize its aims in just a few categories (the remaining chapters of this report describe all the provisions of the Committee bill in full detail). But most of the committee's actions on the bill do fit within a few broad purposes:

- (1) To reward work effort for those who can be expected to work;
- (2) To improve the lives of children;

- (3) To assist those who cannot work because of age, blindness, or disability;
- (4) To assure program integrity through administrative control where this has been shown to be needed; and
- (5) To provide fiscal relief to the States and to give them more latitude to run their own programs.

Rewarding Work Effort for Those Who Can Work

When people look at the rapid growth in welfare in recent years, their concern is primarily with the program of Aid to Families with Dependent Children. The number of recipients under this program has more than doubled since January 1968, and the need to pay for AFDC has forced States to shift funds into welfare that would otherwise go for education, health, and housing and other pressing social needs.

The rising AFDC rolls show that there are many children who are needy in this country. But more importantly from the standpoint of social policy, the rising rolls show an alarming increase in dependency on the taxpayer. The proportion of children in this country who are receiving AFDC has risen sharply, from three percent in the mid-50's to 9 percent today. This means that an increasing number of families are becoming dependent on welfare and staying dependent on welfare.

A major cause of the growth of AFDC is increasing family breakup and increasing failure to form families in the first place. Births out of wedlock, particularly to teen-age mothers, have increased sharply in the past decade.

Several generations ago, before there was any AFDC program, poor families improved their economic conditions by taking advantage of this country's opportunities through a commitment to work, and through the strengthening and maintenance of family ties. The social compassion that gave rise to the AFDC program—particularly in those States in which benefit levels are highest—appears to have had the effect of undermining these routes to economic betterment, with dismal consequences, particularly for the poor on welfare themselves. The House bill, with the major expansion of welfare it contemplates, would move a giant step further along a road that has proven so unsuccessful up to now.

But another approach is possible to improving the lives of low-income families. As President Nixon has stated:

In the final analysis, we cannot talk our way out of poverty; we cannot legislate our way out of poverty; but this Nation can work its way out of poverty. What America needs now is not more welfare, but more "workfare," a new work-rewarding program.

The committee agrees with the President that work should be rewarded and its value to the worker increased. Under the committee bill, over \$2 billion in additional income would be paid to low-income working persons in 1974. A number of other provisions are included in the committee bill which reflects the committee's aim of increasing the benefits of working.

Ten percent work bonus.—Low-income workers in regular employment who head families would be eligible for a work bonus equal to

10 percent of their wages taxed under the social security (or railroad retirement) program if the annual income of the husband and wife is \$4,000 or less. For families where the husband's and wife's annual income exceeds \$4,000, the work bonus would be equal to \$400 minus one-fourth of the amount by which their income exceeds \$4,000. The work bonus, administered by the Internal Revenue Service, would cost about one billion dollars in 1974, and would provide work bonus payments to about five million families.

Wage supplement.—Persons in jobs not covered by the Federal minimum wage law, in which the employer paid less than \$2 per hour but at least \$1.50 per hour, would be eligible for a wage supplement. Any employee who is the head of a household with children and who is working in one of these jobs would be eligible for a wage supplement equal to three-quarters of the difference between what the employer pays him and \$2 per hour (for up to 40 hours a week). Thus if an employer pays a wage of \$1.50 an hour, the Federal subsidy would amount to 38 cents an hour, three-quarters of the 50-cent difference between \$1.50 and \$2.00. In addition, the 15-cent work bonus the employee receives would bring the value of working one hour from the \$1.50 presently paid by the employer up to \$2.03. No supplement would be paid if the employer reduced the pay for the job; no jobs presently paying the minimum wage would be down-graded under the Committee bill, and the minimum wage law itself would not be affected.

Guaranteed job opportunity.—Since welfare programs are based on need as measured by income, decreased work effort results in a higher welfare benefit. This is not the case under the work bonus or the wage supplement under the committee bill, which are directly related to work effort. Similarly, the third basic feature of the committee's employment program rewards work effort directly. This third element is the provision of a guaranteed job opportunity for persons not able to find employment in a regular job. Persons considered to be employable (able-bodied male heads of families, as well as mothers with school-age children only) would no longer be eligible to receive their basic income under the welfare system that has failed both them and society, but instead would be guaranteed an opportunity to earn \$2,400 a year. An individual could work up to 32 hours a week at \$1.50 per hour and would be paid on the basis of hours worked. Just as in any other job, there would be no pay for hours not worked. A woman with school-age children would not be required to be away from home during hours that the children are not in school, unless child care is provided. She may be asked, however, in order to earn her wage, to provide after-school care to children other than her own during the hours she is at home.

Unlike the present welfare program and the House-passed bill, the committee bill would not penalize participants for outside employment. An individual who is able to find part-time employment in addition to the hours worked in the guaranteed job will be able to keep 100 percent of his or her earnings with no reduction in the wages earned in the guaranteed job.

State supplementation.—To assure that the work incentives proposed under the committee bill are not undermined by State welfare programs, the committee bill would require States with welfare bene-

fits of more than \$200 monthly to supplement wages earned by families headed by women participating in the employment program. Furthermore, in determining the amount of the supplementary payment, the State would not be permitted to reduce the payment on account of any earnings between \$200 a month and \$375 a month (the amount an employee would earn, including the work bonus, working 40 hours a week at \$2.00 an hour) to ensure that the incentive system of the committee bill is preserved.

Food stamps.—Individuals participating in the employment program would not be eligible to participate in the food stamp program. However, States would be reimbursed the full cost of adjusting any supplementary benefits they might decide to give to participants so as to make up for the loss of food stamp eligibility. In order to avoid having States provide assistance to an entirely new category of recipient not now eligible for federally-shared Aid to Families with Dependent Children, the committee provided that the Work Administration, which administers the guaranteed job program, would pay families headed by an able-bodied father the amount equal to the value of food stamps (but only to the extent that the State provides cash instead of food stamps for families which are now in the Aid to Families with Dependent Children category).

Child care.—Lack of availability of adequate child care represents perhaps the greatest single obstacle in the efforts of poor families, especially those headed by a mother, to work their way out of poverty. It also represents a hindrance to other mothers in families above the poverty line who wish to seek employment for their own self-fulfillment or for the improvement of their family's economic status. The committee bill incorporates a new approach to the problem of expanding the supply of child care services and improving the quality of these services, through the establishment of a Bureau of Child Care within the Work Administration. In addition to arranging to make child care available, the committee bill would authorize appropriations to subsidize the cost of child care for low-income working mothers.

Other supportive services.—Services needed to continue in employment, including family planning services, would be provided participants in the employment program by the Work Administration.

Medical care.—Under the committee bill, families participating in the employment program who would be eligible for medicaid except for their earnings from employment would remain eligible for medicaid for one year. At that time they could choose to continue their medicaid coverage by paying a premium equal to 20 percent of their income (excluding work bonus payments) in excess of \$2,400 annually. Families participating in the employment program who would be ineligible in any case for medicaid could also voluntarily elect to receive medicaid benefits by paying a premium equal to 20 percent of their income (including work bonus payments) above \$2,400. The committee bill includes an estimated \$200 million in additional Federal payments representing the difference between the value of health care received by these working persons and the cost of the premiums they would actually pay.

Transportation assistance.—The committee recognizes that a major reason for jobs going unfilled in metropolitan areas is the difficulty

individuals face in getting to the job. The committee bill would authorize the Work Administration to arrange for transportation assistance where this is necessary to place its employees in regular jobs.

Developing jobs.—In order to develop job opportunities in the private sector, the committee bill would extend (in a modified form) the present tax credit, for employers who hire participants in the Work Incentive Program, to employers who hire persons in guaranteed employment. In order to create additional employment opportunities, the committee bill would extend the credit to private persons hiring participants.

Special minimum benefit for long-term workers under social security.—For long-time low-income workers, the committee bill contains a provision guaranteeing a minimum social security benefit equal to \$10 per year for each year in covered employment in excess of 10 years. Thus a worker with 30 years of covered employment would be assured of a social security benefit of at least \$200 a month; the minimum payment to a couple would be \$300 a month. A worker retiring in 1972 who has worked all his life at the Federal minimum wage applicable during his employment would be eligible for a monthly benefit of about \$160 today. Under the committee bill, his benefit would be increased 25 percent to \$200, well above the poverty level. Thus the committee bill would achieve the original aim of the Social Security Act of 1935, to provide regular long-term workers with an income that would free them from dependency on welfare. Under this provision of the committee bill, an estimated 700,000 persons would get increased benefits beginning next January, and \$152 million in additional benefits would be paid in the first full year.

Increase in the earnings limit.—Under the committee bill, the amount that a social security 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 \$2,400. For each \$2 of earnings above \$2,400, benefits would be reduced by \$1. An estimated 1.2 million beneficiaries would receive higher benefit payments under this provision, and 550,000 persons would become entitled to benefits for the first time. About \$1.1 billion in additional benefits would be paid in 1974.

Increased benefits for delayed retirement.—The House bill provides for an increase in social security benefits of one percent for each year after age 65 that an individual fails to receive social security benefits because he continues to work instead of retiring. The House bill would apply only to persons beginning to receive social security after the enactment of H.R. 1. The committee felt that the principle of increasing benefits for delayed retirement should apply as well to persons already receiving social security. Under the committee bill, 5 million persons would get increased benefits totaling about \$200 million in the first full year.

Income disregard under supplemental security income for the aged, blind, and disabled.—Under present law, each dollar of social security benefits received generally reduces welfare payments by one dollar. The committee felt that persons receiving social security should receive an economic benefit for the taxes that they paid when they worked to earn entitlement to social security benefits. Accordingly, under the committee bill aged, blind, and disabled persons who receive

social security would be assured a minimum monthly income of at least \$180 for an individual and \$245 for a couple (as compared with \$130 and \$195 for individuals and couples with no other income). In addition to providing a monthly disregard of \$50 of social security or other income, the committee approved an additional disregard for aged, blind, or disabled persons of \$85 of earned income plus one-half of any earning above \$85. This will enable those persons who are able to do some work to do so without suffering a totally offsetting reduction in their supplemental security income payments.

Improving the Lives of Children

The program of Aid to Families with Dependent Children began and remains a program to help needy children; the basis of eligibility for AFDC payments was and remains the presence of a child. The committee bill seeks to improve the lives of children in a number of areas: by providing a higher income for low-income working families with children; by providing for improved health care; by arranging for better child care; by increasing support for child welfare services designed to strengthen family life and to keep the family together; by supporting foster care for children when the child's home is not suitable; by arranging for protective payments to ensure that funds are used in the best interests of the child; by providing a mechanism to ensure the child's right to have the paternity of his father established and to obtain support payments; and by making special provision for emergency assistance to children in families of migrant workers.

Higher income for working families.—The provisions of the committee bill outlined in the preceding section show how the committee bill would provide more than \$2 billion in additional income to low-income working families. In addition, ending the cycle of dependency that now links generation to generation is a major goal of the committee bill, and one which should have a profound effect on the lives of children.

Health care for children.—Under the committee bill several million low-income working persons not now eligible for Government health benefits would be eligible to buy subsidized health care protection for their families. Their premium, equal to 20 percent of their income (excluding work bonus payments) in excess of \$2,400 annually, would pay part of the cost of this protection, with the Federal Government paying the remaining \$200 million in estimated cost. Some million children not now covered under the medicaid program could receive health protection under this provision if their parents elect coverage.

Another provision of the committee bill extends the program of special project grants for maternal and child health. The project grant program has been utilized primarily to bring comprehensive health care to children of low-income families in urban areas.

In 1967 the Congress required that States begin screening all children under age 21 for handicapping conditions. States have failed to meet this requirement, and HEW regulations require States to provide health care screening only to children under age six. The committee added a provision to the bill reiterating that screening services must be provided to all eligible children between ages of 7 and 21 by July 1, 1973. To insure that children receive the screening the Congress

intends, the committee provision would reduce Federal grants for AFDC by two percent beginning July 1, 1974, if a State fails to (a) inform parents receiving AFDC or participating in the employment program of the availability of child health screening services; (b) actually provide or arrange for such services; or (c) arrange for or refer for appropriate corrective treatment, the children disclosed by such screening as suffering illness or impairment.

Medicaid coverage of mentally ill children.—Under present law, Federal matching for the treatment of mentally ill persons under the medicaid program is limited to persons 65 years of age or older. The committee bill would for the first time extend Federal financial participation to inpatient care in mental institutions for children eligible for medicaid. Federal matching would only apply if the care consisted of a program of active treatment, was provided in an accredited medical institution, and provided that the State maintains the level of expenditures it is now making for mentally ill children.

Child care.—The committee bill will significantly improve the care that thousands of children receive while their parents work. Care provided under the committee bill will have to meet Federal standards designed to assure that adequate space, staffing, and health requirements are made. In addition, facilities used will have to meet the life safety code of the National Fire Protection Association.

Protection of children.—The committee bill would require (rather than merely permit) States to assure that welfare payments are being used in the best interests of the children for whom they are intended. When a welfare agency has reason to believe that the Aid to Families with Dependent Children payments are not being used in the best interests of the child, it must provide counseling, and guidance services so that the mother will use the payments in the best interests of the child. This failing, the agency must make protective payments to a third party who will use the funds for the best interests of the child.

Failure to pay rent leads to eviction and disruption of a child's life. The committee therefore provided that if the parent of a child receiving AFDC has failed to make rent payments for two consecutive months, the welfare agency may, depending on the circumstances of the case, make a rent payment directly to the landlord if he agrees to accept the amount actually allowed for shelter by the State as total payment for the rent.

Under the employment program, mothers in families with no children under age six would generally be ineligible to receive their basic income from the Aid to Families with Dependent Children program. It is possible that a few mothers will ignore the welfare of their children and refuse to take advantage of the employment opportunity. To prevent the children from suffering because of such neglect, the Work Administration would be authorized to make payment to the family for up to one month if the mother is provided counseling and other services aimed at persuading her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to vocational rehabilitation agency; or, if she is not found to be incapacitated, the State would arrange for protective payments to a third party to ensure that the needs of the children are provided for.

Child welfare services.—The committee bill would increase the annual authorization for Federal grants to the States for child welfare services to \$200 million in fiscal year 1973, rising to \$270 million in 1977 and thereafter. These figures compare with a \$46 million appropriation in 1972. While it is expected that a substantial part of any increased appropriation under this higher authorization will go toward meeting the cost of providing foster care, the Committee bill (unlike the House bill) avoided earmarking amounts specifically for foster care so that wherever possible States and counties can use the additional funds to expand preventive child welfare services with the aim of helping families stay together, thus avoiding the need for foster care. The additional funds can also be used for adoption services, including action to increase adoption of hard to place children.

The committee bill also provides for establishing a National Adoption Information Exchange System designed to assist in the placement of children awaiting adoption and to make it easier for parents wishing to adopt children to do so.

Child support.—Family breakup and failure to form families in the first place are major factors in the very rapid growth in the AFDC rolls in recent years. New provisions were written into the law in 1967 which unfortunately have proven ineffective in stemming the trend. The committee believes that an effective mechanism for assuring that fathers meet their obligation to support their children, in addition to the immediate effect of reducing welfare costs, will provide a strong deterrent to fathers who might otherwise desert—a deterrent that will keep families intact and will thus have a significant impact on improving the lives of children in the families.

Under this mechanism a mother, as a condition of eligibility for welfare, would assign her right of support payments to the Government. Under the leadership of the Attorney General, States would establish programs of obtaining child support (including the determination of paternity where this is necessary). State expenses for the collection unit established under the committee bill would be provided 75 percent Federal matching instead of 50 percent as under present law. Any information held by the Internal Revenue Service, the Social Security Administration, or other Federal agency would be available to help locate the absent father. This location service could be used by any mother seeking support from a deserting father, even if the family does not receive welfare.

The State collection unit would generally find it desirable to encourage the father to reach a voluntary agreement for making regular support payments. Where the voluntary approach is not successful, the committee bill provides for stronger legal remedies including the collection mechanisms available to the Federal Government such as the use of the Internal Revenue Service to garnishee the wages of the absent parent. The welfare payments to the family would serve as the basis of a continuing monetary obligation of the deserting parent to the United States.

If attempts to obtain support payments are unsuccessful, the committee bill provides for Federal criminal penalties for an absent parent who has not fulfilled his obligation to support his family when

the family receives welfare payments in which the Federal Government participates.

Child's right to have paternity established.—The committee believes that a child born out of wedlock has a right to have his paternity ascertained in a fair and efficient manner, and that society should act on the child's behalf to establish paternity even where this conflicts with the mother's short-term interests. As part of its comprehensive approach to obtain child support, the committee bill includes several provisions designed to lead to a more effective system of establishing paternity.

First, a father not married to the mother of his child would be required to sign an affidavit of paternity if he agreed to make support payments voluntarily in order to avoid court action. Most States do not permit initiation of paternity actions more than two or three years after the child's birth; the affidavit would serve as legal evidence of paternity in the event that court action for support should later become necessary.

Second, there is evidence that blood typing techniques have developed to such an extent that they may be used to establish evidence of paternity at a level of probability acceptable for legal determinations. Moreover, if blood grouping is conducted expertly, the possibility of error can all but be eliminated. Therefore, the committee adopted a provision to authorize and direct the Department of Health, Education, and Welfare to establish or arrange for regional laboratories that can do blood typing for purposes of establishing paternity, so that the State agencies and the courts would have this expert evidence available to them in paternity suits. No requirement would be made in Federal law that blood tests be made mandatory. The services of the laboratories would be available with respect to any paternity proceeding, not just a proceeding brought by, or for, a welfare recipient.

Emergency assistance to migrant families with children.—Under existing law, emergency assistance may, at the option of the States, be provided to needy families in crisis situations, and it may be provided either statewide or in part of the State. Emergency assistance programs have been adopted in about half of the States, and they receive 50 percent Federal matching. Under the law, assistance may be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide living arrangements for the child. The committee bill (1) requires that all States have a program of emergency assistance to migrant families with children; (2) requires that the program be statewide in application; and (3) provides 75 percent Federal matching for emergency assistance to migrant families.

Social security provisions related to benefits for children.—The committee bill contains several provisions related specifically to children's benefits, which would: (1) Extend social security coverage to certain grandchildren not adopted by their grandparents; (2) provide childhood disability benefits if the disability began before age 22 rather than before age 18 as under present law; and (3) liberalize the eligibility requirements for children adopted by social security beneficiaries.

Aiding Aged, Blind, and Disabled Persons

The committee continues to place primary reliance on the social security system to provide income to aged, blind, and disabled persons, and as in the past considers it appropriate for workers to contribute during their productive working years as they build up entitlement to retirement, disability, and survivor benefits. The social security program has succeeded remarkably well in its original intention of replacing old age assistance. The proportion of aged persons receiving social security has mounted steadily since 1940 until the program is now nearly universal, while at the same time the proportion of the aged population receiving welfare has declined from 23 percent of the elderly 30 years ago to 10 percent today. Building on the 20-percent benefit increase already enacted into law, the committee bill would create a new Supplemental Security Income program, administered by the Social Security Administration, which would set a Federal guaranteed minimum income level for aged, blind, and disabled persons, with higher incomes guaranteed for those entitled to social security benefits.

Benefits for widows.—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 who begins receiving benefits at age 65 or after would receive 100 percent (rather than 82½ percent as under present law) of the amount her deceased husband was receiving at his death, or the amount he would have received if he had begun getting benefits at age 65. Under this provision \$1.1 billion in additional benefits would be paid to 3.8 million persons in 1974.

Extension of medicare to the disabled.—The major provision in the committee bill affecting blind and disabled social security beneficiaries would extend medicare coverage to 1.7 million disabled social security beneficiaries at a cost of \$1.5 billion in the first full year for hospital insurance and \$350 million for a supplementary medical insurance.

Reduction in waiting period for disability benefits.—Under present law, an individual must be disabled throughout a full six-month period before he may be paid disability insurance benefits. Under the committee bill, the waiting period would be reduced two months to a 4-month period. An estimated 950,000 beneficiaries would become entitled to \$274 million in additional benefits under this provision in 1974.

Disability benefits for the blind.—The committee bill substantially liberalizes the provisions of present law relating to blind persons. In particular, the committee bill would make blind persons with at least six quarters of coverage eligible for disability benefits, and permit blind persons to qualify for benefits regardless of their capacity to work and whether they are working.

Coverage of drugs under medicare.—The cost of outpatient prescription drugs represents a major item of medical expense for many older people, especially those suffering from chronic conditions. The costs of such drugs are not presently covered under the medicare program. The committee bill would cover under the medicare program the cost of certain specified drugs purchased on an outpatient basis which are necessary in the treatment of the most common crippling or life-threatening chronic disease conditions of the aged. Beneficiaries

would pay \$1 toward the cost of each prescribed drug included in the reasonable cost range for the drug involved.

Limiting the premium for supplementary medical insurance.—During the first 5 years of the program it has been necessary to increase the part B premium almost 100 percent—from \$3.00 monthly per person in July 1966 to a \$5.80 rate in July 1972. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate.

The committee bill would limit part B premium increase to not more than the percentage by which the social security cash benefits had been generally increased since the last part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching.

Medicare coverage for spouses and social security beneficiaries under age 65.—Under present law, medicare coverage is restricted to persons age 65 and over, but persons age 60 through 64 (including retired workers, their spouses, widows, or parents) find it difficult to obtain adequate private health insurance at a rate which they can afford. The committee bill would make medicare protection available at cost to spouses age 60 to 64 of medicare beneficiaries and to other persons age 60 to 64 entitled to benefits under the Social Security Act.

Supplementary security income for the aged, blind, and disabled.—Under present law, aged, blind, and disabled persons are eligible for welfare benefits under the various State assistance programs, with the State setting the payment levels. The committee bill would substitute instead a new federally administered program of supplemental security income for aged, blind, and disabled persons. Under this program, aged, blind, and disabled individuals would be assured a monthly income of at least \$130 for an individual or \$195 for a couple. In addition the committee bill would provide that the first \$50 of social security or other income would not cause any reduction in amount of the supplementary security income payment.

As a result, aged, blind, and disabled persons who also have monthly income from social security or other sources (which are not need-related) of at least \$50 would, under the committee bill, be assured total monthly income of at least \$180 for an individual or \$245 for a couple.

Use of trust funds for rehabilitation.—Under present law, up to one percent of the amount of social security trust funds paid to disabled beneficiaries in the prior year may be used to pay for the costs of rehabilitating disabled beneficiaries. In order to provide additional funds for rehabilitating these disabled persons, the committee bill would increase by 50 percent the percentage of the trust funds which could be used for rehabilitation.

Rehabilitation of alcoholics and addicts.—The committee is particularly concerned that persons who are disabled because of alcoholism or drug addiction be provided rehabilitative services under a program of active treatment rather than simply being provided income with which to support their addiction or alcoholism. Accordingly, alcoholics and drug addicts under the committee bill would be able

to receive maintenance payments only as part of a program of active treatment.

Improving Program Integrity and Enhancing Quality of Care

The committee bill includes a number of provisions designed to improve administrative control and quality of care assurance in the medicare and medicaid programs and to restore the integrity of the welfare programs.

Establishment of Professional Standards Review Organizations.—The committee has found substantial indications that a significant amount of health services paid for under the medicare and medicaid programs would not be found medically necessary under appropriate professional standards. In some instances, the services provided are of unsatisfactory professional quality.

The committee bill would establish Professional Standards Review Organizations, sponsored by organizations representing substantial numbers of practicing physicians in local areas, to assume responsibility for comprehensive and ongoing review of services covered under the medicare and medicaid programs. The purpose of the amendment would be to assure proper utilization of care and services provided in medicare and medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption in carrying out of the important review activities in the two highly expensive programs. The amendment provides discretion for recognition of and use by the PSRO of effective utilization review committees in hospitals and medical organizations.

Inspector General for medicare and medicaid.—There is at present no independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of medicare and medicaid in terms of the efficiency and effectiveness of program operations and compliance with congressional intent. While HEW's Audit Agency and the General Accounting Office have done helpful work, there is a need for day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

The committee bill would create the Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the social security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the statute and congressional intent.

Limitations on coverage of costs under medicare.—The committee bill authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except

that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of costs determined as not "necessary" to efficient patient care.

Limitation on prevailing charge levels.—Under the present reasonable charge policy, medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase medicare payments and costs.

The committee bill recognizes as reasonable, for medicare reimbursement purposes only, those charges which fall within the 75th percentile. Starting in 1973, increases in physicians' fees allowable for medicare purposes, would be limited by a factor which takes into account increased costs of practice and the increase in earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the amendment would provide for recognizing only the lower charges at which supplies of similar quality are widely available.

Public disclosure of information regarding deficiencies.—Physicians and the public are currently unaware as to which hospitals, extended care facilities, skilled nursing home and intermediate care facilities have deficiencies and which facilities fully meet the statutory and regulatory requirements. This operates to discourage the direction of physician, patient, and public concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Under the bill the Secretary of Health, Education, and Welfare would be required to make reports of an institution's significant deficiencies or the absence thereof (such as deficiencies in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available at social security district offices. Following completion of a survey of a health care facility or organization, those portions of the survey relating to statutory requirements as well as those additional significant survey aspects required by regulations relating to the capacity of the facility to provide proper care in a safe setting would be matters of public record.

Determining eligibility for welfare.—Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant's home and from other sources. For persons found eligible for assistance, redetermination of eligibility is required at least annually, and similar procedures are followed.

The Department of Health, Education, and Welfare has required States to use a simplified or "declaration method" for aid to aged, blind, and disabled, and has strongly urged that this method be used in the program of Aid to Families with Dependent Children. The simplified or "declaration method" provides for eligibility determinations to be based to the maximum extent possible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the caseworker. The committee bill precludes the use of the declaration method by law. It also

explicitly authorizes the States in the statute to examine the application or current circumstances and promptly make any verification from independent or collateral sources necessary to insure that eligibility exists. The Secretary could not, by regulation, limit the State's authority to verify income or other eligibility factors.

Recouping overpayments.—In 1970 the Supreme Court ruled that welfare payments could not be terminated before a recipient is afforded an evidentiary hearing. The Health, Education, and Welfare regulations based on the court's decision permit the recipient to delay the hearing in order to continue to receive welfare payments long after he has become ineligible. Other regulations virtually preclude recovering overpayments.

The committee bill deals with this situation by requiring State welfare agencies to reach a final decision on the appeal of a welfare recipient within 30 days following the day the recipient was notified of the agency's intention to reduce or terminate assistance. The bill would also require the repayment to the agency of amounts which a recipient received during the period of the appeal if it was determined that the recipient was not entitled to them.

Quality of work performed by welfare personnel.—In an effort to try to upgrade the quality of work performed by welfare personnel, the committee bill directs the Secretary of the Department of Health, Education, and Welfare to study and report to the Congress by January 1, 1974, on ways of enhancing the quality of welfare work, whether by fixing standards of performance or otherwise. In making this study, the Secretary could draw on the knowledge and expertise of persons talented in the field of welfare administration, including those having direct contact with recipients. He should also benefit from suggestions made by recipients themselves as to how the level of performance in the administration of the welfare system might be improved, with a view toward ending the wide variations in employee conduct which characterize today's system, and moderating the extremes to which some social workers go in performing their duties.

Offenses by welfare employees.—Under present Federal law there is no provision particularly directed to the question of employee conduct in the administration of the welfare program. Under the committee bill, rules similar to those applicable to Internal Revenue Service, employees would apply under the welfare laws. The committee is hopeful that this provision could lead to an upgrading of the quality of performance by welfare workers in general.

Fiscal Relief for States and Additional Administrative Latitude

The committee is well aware that the growth of the welfare rolls since 1967 has been one of the significant factors in bringing about the fiscal crisis currently facing State and local governments. Much of this growth has been due to increased Federal intervention in the control of the AFDC program by the States. The committee feels that having the Federal Government take over the control of this program is not the step that should be taken. It believes that the correct approach is in the opposite direction. Accordingly, the committee carefully designed many parts of this bill so that the State's control of the AFDC program would be strengthened rather than weakened. The

committee recognizes, however, that this represents a long-range solution and that many States feel an acute need for immediate relief from the pressures of swollen welfare budgets. Under the committee bill therefore, the fiscal burden on the States will be substantially decreased through creation of the new Federal Supplemental Security Income program in lieu of the present program of aid to the aged, blind, and disabled, through increases in the Federal funding of assistance payments to families, and through indirect fiscal relief resulting from improvements which the committee bill makes in the general structure of the AFDC program.

Supplemental security income for the aged, blind, and disabled.—The committee bill establishes a new program of supplemental security income for the aged, blind, and disabled, with Federal administration and with the Federal Government paying the full cost of the program as a replacement of the present Federal-State programs of aid to the aged, blind, and disabled, this new program will save States about \$800 million annually.

Aid to Families with Dependent Children.—In the Aid to Families with Dependent Children program, the committee bill changes the funding mechanism from the present formula matching to a block grant approach. This new method of providing Federal funds for AFDC results in substantial immediate fiscal relief and is also consistent with the committee's desire to return to the States a greater measure of control over their welfare programs. For the last 6 months of calendar year 1972 and for 1973 the block grant would be based on the funding for calendar year 1972 under current law. Starting in 1974 the grant would be adjusted to take into account the effects of the work program.

Child welfare services.—Federal appropriations for child welfare services have remained at \$46 million for the past 7 years, representing about one-seventh of total State and local expenditures for child welfare services programs. The committee bill would increase the authorizations for child welfare services to \$200 million in fiscal year 1973 rising to \$270 million in fiscal year 1977 and thereafter.

State medicaid savings.—The provisions of the committee bill extending medicare coverage to disabled social security beneficiaries, including prescription drugs under the medicare program, and providing Federal medicaid matching for the first time for mentally ill children will save States substantial amounts under their medicaid programs.

Limiting regulatory authority of the Secretary of Health, Education, and Welfare.—The Social Security Act permits the Secretary of Health, Education, and Welfare to "make and publish such rules and regulations, not inconsistent with this act, as may be necessary to the efficient administration of the functions" with which he is charged under the act. Similar authority is provided under each of the welfare programs. Particularly since January 1969, regulations have been issued under this general authority with little basis in law and which sometimes have run directly counter to legislative history. Many States have attributed at least a part of the growth of the welfare caseload in recent years to these regulations of the Department of Health, Education, and Welfare.

A number of committee decisions deal with problems raised by specific HEW regulations. In addition, the committee agreed to

modify the statutory language quoted above by limiting the Secretary's regulatory authority under the welfare programs so that he may issue regulations only with respect to specific provisions of the act and even in these cases the regulations may not be inconsistent with the provisions of the Act.

Permitting States more latitude under medicaid.—The medicaid program has been a significant burden on State finances. Two requirements of present law would be deleted by the committee bill. These requirements prevent a State from ever reducing medicaid expenditures and require that a State medicaid program ever expand until the program is comprehensive.

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

Summary of Principal Provisions of the Bill

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II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Social Security Cash Benefits

1. PROVISIONS OF THE HOUSE BILL CHANGED AND NEW PROVISIONS ADDED BY THE COMMITTEE

SPECIAL MINIMUM CASH BENEFITS

The House-passed bill would provide a special minimum benefit of \$5 multiplied by the number of years in covered employment up to 30 years, producing a benefit of at least \$150 a month for a worker who has been employed for 30 years under social security coverage. The committee bill replaces this with a provision for a special minimum benefit under the social security program which would provide a payment of \$200 per month (\$300 for a couple) for persons who have been employed in covered employment for 30 years. This benefit would be paid as an alternative to the regular benefits in cases where a higher benefit would result.

Under this provision, the new higher minimum benefit would become payable to people with 19 or more years of employment; at that point, the special minimum benefit would be more than the regular minimum—\$85 as compared to the regular minimum benefit of \$84.50 which under present law will be payable starting in October. A worker with 20 years of employment under social security would thus be guaranteed a benefit of at least \$100; one with 25 years would be guaranteed at least \$150, while one with 30 years would receive at least \$200 a month. Minimum payments to a couple would be one and one-half times these amounts.

Effective date.—January 1973.

Number of people affected and dollar payments.—700,000 people would get increased benefits on the effective date and \$152 million in additional benefits would be paid in 1974.

INCREASED BENEFITS FOR THOSE WHO DELAY RETIREMENT BEYOND AGE 65

The committee bill includes the provision in the House bill which would provide for an increase in social security benefits of 1 percent for each year after age 65 that the individual delays his retirement. However, the committee modified the provision so that the additional benefit would apply to persons already retired, rather than only to those coming on the social security rolls after the bill's enactment.

Effective date.—January 1973.

(27)

Number of people affected and dollar payments.—5 million people would get increased benefits on the effective date and \$198 million in additional benefits would be paid in 1974.

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 \$1,600 to \$2,400 in the committee bill (compared with \$2,000 in the House bill). Under present law, benefits are reduced by \$1 for each \$2 of earnings between \$1,680 and \$2,800 and for each \$1 of earnings above \$2,880. The committee bill would provide for a \$1 reduction for each \$2 of all earnings above \$2,400, 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.

Future increases in the amount of exempt earnings would be automatic as average earnings rise.

Effective date.—January 1973.

Number of people affected and dollar payments.—1.2 million beneficiaries would become entitled to higher benefit payments on the effective date and 550,000 additional people would become entitled to benefits. About \$1.1 billion in additional benefits would be paid in 1974.

REDUCTION IN WAITING PERIOD FOR DISABILITY BENEFITS

Under the House bill, the present 6-month period throughout which a person must be disabled before he can be paid disability benefits would be reduced by 1 month (to 5 months). Under the committee bill, the waiting period would be reduced 2 months to a 4-month period.

Effective date. January 1973.

Number of people affected and dollar payments.—950 thousand beneficiaries would become entitled to additional benefit payments in 1974 and 8 thousand additional people would become entitled to benefits. About \$274 million in additional benefits would be paid in 1974.

DISABILITY BENEFITS FOR INDIVIDUALS WHO ARE BLIND

The committee bill includes provisions not contained in the House-passed bill: (a) making disability benefits payable to blind persons who have six quarters of coverage earned at any time; (b) changing the definition of disability for the blind to permit them to qualify for benefits regardless of their capacity to work and whether they work; (c) permitting the blind to receive disability benefits beyond age 65 without regard to the retirement test; and (d) excluding the blind from the requirement that disability benefits be suspended when a beneficiary refuses without good cause to accept vocational rehabilitation.

Effective date.—January 1973.

Number of people affected and dollar payments.—250 thousand additional people would become eligible for benefits on the effective date and \$246 million in additional benefits would be paid in 1974.

**PAYMENTS BY AN EMPLOYER TO THE SURVIVOR OR ESTATE OF A FORMER
EMPLOYEE OR TO A DISABLED FORMER EMPLOYEE**

Under the House-passed bill 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. The committee bill extends this provision to payments made to disability insurance beneficiaries.

Effective date.—January 1973.

**ISSUANCE OF SOCIAL SECURITY NUMBERS AND PENALTY FOR FURNISHING
FALSE INFORMATION TO OBTAIN A NUMBER**

The committee bill includes a number of provisions (not included in the House bill) dealing with the method of issuing social security account numbers. Under present law, numbers are issued upon application, often by mail, upon the individual's motion.

Under a committee amendment, numbers in the future generally would be issued at the time an individual enters the school system; for most persons, this would be the first grade. In the case of non-citizens entering the country under conditions which would permit them to work, numbers would be issued at the time they enter the country or in the case of a person who may not legally work at the time he is admitted to the United States, the number would be issued at the time his status changes. In addition to these general rules, numbers would be issued to persons who do not have them at the time they apply for benefits under any federally financed program.

As a corollary to this more orderly system of issuing social security account numbers, the committee bill would provide criminal penalties for (1) knowingly and willfully using a social security number that was obtained with false information or (2) using someone else's social security number. The penalty would involve a fine of up to \$1,000 or imprisonment for up to 1 year or both. These criminal penalties perfect and improve upon features of the House bill relating to false information with respect to social security numbers.

Effective date.—January 1973.

UNDERPAYMENTS

The committee bill includes a provision not contained in the House bill, under which additional relatives (by blood, marriage, or adoption) would be added to the present categories of persons listed in the law who may receive social security cash payments due a deceased beneficiary.

Effective date.—January 1973.

**TREATMENT OF INCOME FROM SALE OF CERTAIN LITERARY OR
ARTISTIC ITEMS**

The committee bill includes a provision (not contained in the House bill) to exclude income from sale of certain literary or artistic items created before age 65 from income for purposes of determining the

amount of benefits to be withheld under the social security earnings test. Under existing law, such income is not counted if the literary work was copyrighted before age 65. Under the amendment, the time of copyright is immaterial so long as the work which produced the literary or artistic item was performed before age 65.

Effective date.—January 1973.

BENEFITS FOR A CHILD BASED ON THE EARNINGS RECORD OF A GRANDPARENT

Under the House bill, coverage would be extended to grandchildren not adopted by their grandparents if their parents have died and if the grandchildren were living with a grandparent at the time the grandparent qualified for benefits. The committee approved the House provision but extended it to instances where the grandchild's parents are totally disabled, and the grandchild is living with a grandparent.

Effective date.—January 1973.

BENEFITS FOR DISABLED AND DEPENDENT SISTERS AND BROTHERS

The committee bill includes a provision (not contained in the House bill) to extend social security coverage to disabled, dependent sisters and brothers.

Effective date.—January 1973.

Number of people affected and dollar payments.—50 thousand additional people would become eligible for benefits on the effective date and \$79 million in additional benefits would be paid in the first full year.

REFUND OF SOCIAL SECURITY TAX TO MEMBERS OF CERTAIN RELIGIOUS FAITHS OPPOSED TO INSURANCE

Under present law, members of certain religious sects who have conscientious objections to social security by reason of their adherence to the established teachings of the sect may be exempt from the social security self-employment tax provided they also waive their eligibility for social security benefits. This exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

The committee bill would extend the exemption (by a refund or credit against income taxes at year end) from social security taxes to members of the sect who are "employees" covered by the Social Security Act as well as the "self-employed" members of the sect. The employee would have to file an application for exemption from the tax and waive his eligibility for social security and medicare benefits just as the self-employed members must presently do. The provisions specifically provides that there would be no forgiveness of the employer portion of the social security tax as the committee believes this would create an undesirable preference in the statute.

Effective date.—January 1973.

DEATH BENEFITS WHERE BODY IS UNAVAILABLE FOR BURIAL

Under Public Law 92-223, expenses of memorial services can be counted as funeral expenses for the purpose of the social security lump sum death payment, even though the body is unavailable for burial or cremation. The provision applies only with respect to deaths after December 29, 1971. The committee bill would cover deaths occurring after 1960, thus spanning the entire period of the Southeast Asian conflict.

2. PROVISIONS OF THE HOUSE BILL THAT WERE NOT CHANGED BY THE COMMITTEE

INCREASE IN WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

Under present law, when benefits begin at or after age 62 the benefit for a widow (or dependent widower) is equal to 82½ percent of the amount the deceased worker would have received if his benefit had started when he was age 65. A widow can get a benefit at age 60 reduced to take account of the additional 2 years in which she would be getting benefits.

Both the House bill and 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.

Under the 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 widows' benefits are reduced under present law when they begin drawing benefits between ages 60 and 62) to take account of the longer period over which the benefit would be paid.

Effective date.—January 1973.

Number of people affected and dollar payments.—3.8 million people would get increased benefits on the effective date and \$1.1 billion 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, benefit eligibility is figured up to age 65 for men, but only up to age 62 for women. Under both the House bill and the committee bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

Effective date.—The new provision would become effective, starting January 1973, over a 3-year transition period.

Dollar payments.—About \$14 million in additional benefits would be paid in 1974.

DEPENDENT WIDOWER'S BENEFITS AT AGE 60

Aged dependent 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 1973.

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 1973.

Number of people affected and dollar payments.—13,000 additional people would become eligible for benefits on the effective date and \$17 million in additional benefits would be paid in 1974.

CONTINUATION OF CHILD'S BENEFITS THROUGH THE END OF A 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 1973.

Number of people affected and dollar payments.—55 thousand beneficiaries would become entitled to higher benefit payments on the effective date and 6 thousand additional people would become entitled to benefits. About \$19 million in additional benefits would be paid in 1974.

ELIGIBILITY OF 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 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 1973.

NONTERMINATION OF CHILD'S BENEFITS BY REASON OF ADOPTION

Under present law, a child's entitlement to 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.

Under the bill, a child's benefits would no longer stop when the child is adopted, regardless of who adopts him.

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 these support requirements for divorced wives, divorced widows, and surviving divorced mothers.

Effective date.—January 1973.

Number of people affected and dollar payments.—10 thousand additional people would become eligible for benefits on the effective date and \$23 million in additional benefits would be paid in 1974.

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 9 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 3 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 1973.

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 worker's survivors if an application for benefits is filed within 3 months after the worker's death, or within 3 months after enactment of the provision. It would be effective 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 1 year of his highest earnings in a period consisting of the year of disablement and the 5 preceding years.

Effective date.—January 1973.

Number of people affected and dollar payments.—40 thousand people would get increased benefits on the effective date and \$22 million in additional benefits would be paid in 1974.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

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 \$300 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 1973.

Number of people affected and dollar payments.—130 thousand people would get increased benefits on the effective date and \$46 million in additional benefits would be paid in 1974.

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.—January 1973.

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.—January 1973.

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 for social security and income tax purposes. The bill would provide that U.S. citizens who are self-employed outside the United States 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 for self-employment for social security purposes in the same way as those who are self-employed in the United States.

Effective date.—January 1973.

TRUST FUND EXPENDITURES FOR REHABILITATION SERVICES

The bill provides an increase in the amount of social security trust fund moneys 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 1¼ percent for fiscal year 1973 and to 1½ percent for fiscal year 1974 and subsequent years.

Dollar expenditures.—\$29 million in additional expenditures for vocational rehabilitation would be made in 1974.

RECOMPUTATION OF BENEFITS BASED ON COMBINED RAILROAD AND SOCIAL SECURITY 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.

Effective date.—January 1973.

3. OTHER CASH BENEFIT AMENDMENTS

Other amendments included in the committee bill relate to the executive pay level of the Commissioner of Social Security, the coverage of U.S. missionaries working outside the United States; wage credits for Americans of Japanese ancestry who were interned by the U.S. Government during World War II; retroactive benefits for certain disabled persons; social security benefits for a child entitled on the earnings record of more than one worker; coverage of registrars of voters in Louisiana; coverage of certain policemen and firemen in West Virginia and Idaho and certain hospital employees in New Mexico; coverage of certain employees of the Government of Guam; coverage of Federal Home Loan Bank employees; social security coverage for students employed at State operated schools; permitting State and local policemen and firemen to withdraw from social security without affecting the coverage of other public employees; and acceptance of money gifts made unconditionally to social security.

4. PROVISIONS DELETED FROM HOUSE-PASSED BILL

In view of the enactment of Public Law 92-336, the committee bill does not contain the House-passed provisions relating to a general benefit increase, automatic cost-of-living increases in benefits, and automatic increases in the tax base and a guarantee of no decrease in family benefits.

The committee also deleted the House-passed amendments relating to actuarially reduced benefits in one category not being made applicable to certain benefits in other categories; computation of benefits based on combined earnings of a married couple; and to the dropping of additional years of low earnings from the computation of average earnings.

B. Principal Medicare-Medicaid Provisions

1. PROVISIONS OF HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY COMMITTEE

MEDICARE COVERAGE FOR DISABLED BENEFICIARIES

(Sec. 201 of the bill)

Problem

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. In addition, disabled persons are often unable to obtain private health insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, a social security disability beneficiary would be covered under medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled widows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.7 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is \$1.5 billion for hospital insurance and \$350 million for supplementary medical coverage.

HOSPITAL INSURANCE FOR THE UNINSURED

(Sec. 202 of the bill)

Problem

A substantial number of people reaching or presently over age 65 are ineligible for Social Security and thus cannot secure part A (hospital insurance) coverage under medicare. These people have difficulty in securing private health insurance coverage with benefits as extensive as those of medicare.

Finance Committee Amendment

The committee bill will permit persons age 65 or over who are ineligible for part A of medicare to voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially estimated at \$33 monthly and to be recalculated annually). Where the Secretary of HEW finds it administratively feasible, those State and other public employee groups which have, in the past, voluntarily elected *not* to participate in the Social Security program could opt for and pay the part A premium costs for their retired or active employees age 65 or over.

The Finance Committee amendment requires enrollment in part B of medicare as a condition of buying into part A.

PART B PREMIUM CHARGES

(Sec. 203 of the bill)

Problem

During the first 5 years of the program it has been necessary to increase the part B premium almost 100 percent—from \$3.00 monthly per person in July 1966 to the present \$5.80 rate. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate.

Finance Committee Amendment

The committee bill will limit part B premium increases to not more than the percentage by which the Social Security cash benefits had been generally increased since the last part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching.

AUTOMATIC ENROLLMENT FOR PART B

(Sec. 206 of the bill)

Problem

Under present law, eligible individuals must initiate action to enroll in part B of medicare. Nearly 96 percent of eligible older people so enroll. Some eligibles, however, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, the change provides for automatic enrollment under part B for the elderly and the disabled as they become eligible for part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES' BENEFITS

(Sec. 210 of the bill)

Problem

Federal retirees and older employees have been required to take full coverage and pay full premiums for Federal employee coverage despite the fact that the Federal Employees' Programs *will not pay* any benefits for services covered under medicare. Thus the retiree, who also has earned entitlement to medicare, is paying a portion of his premium to F.E.P. for coverage for which no benefits will be paid him. This is

particularly true in the case of hospitalization. The F.E.P. does not presently offer such employees or retirees with dual eligibility the option of electing a lower-cost policy or one which supplements rather than duplicates medicare benefits.

Finance Committee Amendment

Effective January 1, 1975, medicare would not pay a beneficiary, who is also a Federal retiree or employee, for services covered under his Federal employee's health insurance policy which are also covered under medicare unless he has had an option of selecting a policy *supplementing* medicare benefits. If a supplemental policy is not made available, the F.E.P. would then have to pay first on any items of care which were covered under both the F.E.P. program and medicare.

LIMITATION ON FEDERAL PAYMENTS FOR DISAPPROVED CAPITAL
EXPENDITURE

(Sec. 221 of the bill)

Problem

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local health care facilities planning council and still be reimbursed by medicare and medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

Finance Committee Amendment

The committee bill will prohibit reimbursement to providers under the medicare and medicaid programs for capital costs associated with expenditures of \$100,000 or more which are specifically determined to be inconsistent with State or local health facility plans.

EXPERIMENTS IN PROSPECTIVE REIMBURSEMENT AND PEER REVIEW

(Sec. 222 of the bill)

Problem

Reimbursement on the present reasonable costs basis contains little incentive to decrease costs or to improve efficiency, and retrospective cost-finding and auditing have caused lengthy delays and confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, under prospective payment providers might press for a rate less favorable to the Government than the present cost method, and they might cut back on the quality, range and frequency of necessary services so as to reduce costs and maximize return.

Finance Committee Amendment

The committee bill instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments. In view of its adoption of the Professional Standards Review amendment, the committee deleted the portion of this section authorizing peer review experimentation.

LIMITATIONS ON COVERAGE OF COSTS

(Sec. 223 of the bill)

Problem

Certain institutions may incur excessive costs, relative to comparable facilities in the same area, as a result of inefficiency or "the provision of amenities in plush surroundings." Such excessive costs are now reimbursed under medicare.

Finance Committee Amendment

The committee bill authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of costs determined as not "necessary" to efficient patient care.

In cases where emergency care is involved, however, patients would not be liable for any differential in costs related to the emergency care.

LIMITATION ON PREVAILING CHARGE LEVELS

(Sec. 224 of the bill)

Problem

Under the present reasonable charge policy, medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase medicare payments and costs.

Finance Committee Amendment

The committee bill recognizes as reasonable, for medicare reimbursement purposes only, those charges which fall within the 75th percentile. Starting in 1973, increases in physicians' fees allowable for medicare purposes, would be limited by a factor which takes into account increased costs of practice and the increase in earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the amendment would provide for recognizing only the lower charges at which supplies of similar quality are widely available.

PAYMENT FOR PHYSICIANS' SERVICES IN THE TEACHING SETTING

(Sec. 227 of the bill)

Problem

Physicians in private practice are generally reimbursed on a fee-for-service basis for care provided to their bona fide private patients. Difficulties have arisen in determining how and whether payments should be made in teaching hospitals where the actual care is often

rendered by interns and residents under the direction (sometimes nominal) of an attending physician who is assigned to (but not selected by) the medicare patient.

The issue relates to the compensation of the attending physician often termed the supervisory or teaching physician. The salaries of interns and residents are now covered in full as a part A hospital cost. In general, patients were not billed for the services of teaching physicians prior to medicare and, since medicare, billings have been essentially limited to medicare and medicaid patients. The proceeds are most frequently used to finance and subsidize medical education rather than being paid directly to the teaching doctor. While charges have often been billed on a basis comparable to those charged by a private physician to his private patients the services provided are often less.

Finance Committee Amendment

The committee bill provides that services of teaching physicians would be reimbursed on a costs basis unless:

- (A) The patient is bona fide private or;
- (B) The hospital has charged all patients and collected from a majority on a fee-for-service basis.

For donated services of teaching physicians, a salary cost would be imputed equal to the prorated usual costs of full-time salaried physicians. Any such payment would be made to a special fund designated by the medical staff to be used for charitable or educational purposes.

ADVANCE APPROVAL OF ECF AND HOME HEALTH COVERAGE

(Sec. 228 of the bill)

Problem

Uncertainty about determinations of eligibility for care in an extended care facility or home health program following hospitalization has created major difficulties for intermediaries, institutions and beneficiaries. The essential problem is in determining whether the patient is in need of skilled nursing and medical services or in fact, needs a lesser level of care. Retroactive claims denials resulting from determinations that skilled care was not required, while often justified, have created substantial friction and ill will.

Finance Committee Amendment

The committee bill authorizes the Secretary to establish, by diagnosis, minimum periods during which the post-hospital patient would be presumed to be eligible for benefits.

TERMINATION OF PAYMENT TO SUPPLIERS OF SERVICE

(Sec. 229 of the bill)

Problem

Present law does not provide authority for the Secretary to withhold future payments for services rendered by an institution or physician who abuses the program, although payments for past claims may be withheld on an individual basis where the services were not reasonable or necessary.

Finance Committee Amendment

The Secretary would be authorized to suspend or terminate medicare payments to a provider found to have abused the program. Further, there would be no Federal participation in medicaid payments which might be made subsequently to this provider. Program review teams would be established in each State to furnish the Secretary with professional advice in discharging this authority.

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD
COMPREHENSIVE MEDICAID PROGRAM

(Sec. 230 of the bill)

Problem

The medicaid program has been a significant burden on State finances. Section 1903(e) of title 19 requires each State to show that it is making efforts in the direction of broadening the scope of services in its medicaid program and liberalizing eligibility requirements for medical assistance. These required expansions of medicaid programs have been forcing States to either cut back on other programs or to consider dropping medicaid. The original date for attainment of those objectives was 1975. The Finance Committee, the Senate and the House approved an amendment in 1969 postponing the date to 1977.

Finance Committee Amendment

The committee bill would repeal section 1903(e).

RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH
PROGRAMS

(Sec. 240 of the bill)

Problem

State agencies often cannot make pre-payment arrangement which might result in more efficient and economical delivery of health services to medicaid recipients because such arrangements might violate present title 19 requirements that the same range and level of services be available to all recipients throughout the State.

Finance Committee Amendment

The committee bill would permit States to waive Federal state-wideness and comparability requirements with approval of the Secretary if a State contracts with an organization which has agreed to provide health services in excess of the State plan to eligible recipients who reside in the area served by the organization and who elect to receive services from such organization. Payment to such organizations could not be higher on a per-capita basis than the per-capita medicaid expenditures in the same general area.

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH
CARE PERSONNEL

(Sec. 241 of the bill)

Problem

There is a shortage of qualified manpower in the health care field and many facilities have difficulty hiring sufficient qualified personnel.

At the same time there are persons available who do not meet full licensing or medicare educational requirements, but who have had years of experience and have been granted "waivered" status (for example, waivered licensed practical nurses).

Finance Committee Amendment

The committee bill would require the Secretary to develop and apply appropriate means of determining the proficiency of health personnel who are disqualified or restricted in responsibility under present regulations because of lack of formal training or educational requirements.

In order to encourage young people to complete required training, all health personnel initially licensed after Dec. 31, 1977 would be expected to meet otherwise required formal educational and training criteria.

PENALTIES FOR FRAUDULENT ACTS AND FALSE REPORTING UNDER
MEDICARE AND MEDICAID

(Sec. 242 of the bill)

Problem

Present penalty provisions applicable to medicare do not specifically include as fraud such practices as kickbacks and bribes. There is no criminal penalty provision applicable to medicaid. Additionally, there are no penalties at present for false reporting with respect to health and safety conditions in participating institutions.

Finance Committee Amendment

The committee bill would establish penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefits with intent to defraud, or for converting benefit payments to improper use, of up to one year's imprisonment and a \$10,000 fine or both. Concealing knowledge of events affecting a person's right to benefits with intent to defraud, and converting benefits to improper use would also be a Federal crime subject to the same penalty. Additionally, the bill establishes false reporting of a material fact as to conditions or operations of a health care facility as a misdemeanor subject to up to 6 months' imprisonment, a fine of \$2,000, or both.

PROSTHETIC LENSES FURNISHED BY OPTOMETRISTS UNDER PART B

(Sec. 264 of the bill)

Problem

Medicare will pay for prosthetic lenses furnished by an optometrist, provided that the medical necessity for such lenses has been determined by a physician.

Optometrists contend that to require their patients to obtain a physician's order for prosthetic lenses is unfair to both the patient and the optometrist. Moreover, because the physician who furnishes the order is generally an ophthalmologist, the requirement may serve to encourage patients to use an ophthalmologist in preference to an optometrist.

Finance Committee Amendment

The committee bill provides that an optometrist be recognized as a "physician" under section 1861(r) of the Act, but only with respect to establishing the medical necessity of prosthetic lenses for medicare beneficiaries. An optometrist would not be recognized as a "physician" for any other purposes under medicare and no additional services performed by optometrists would be covered by the proposal.

2. PROVISIONS OF HOUSE BILL SUBSTANTIALLY MODIFIED BY COMMITTEE

FAILURE BY STATE TO UNDERTAKE REQUIRED INSTITUTIONAL CARE REVIEW ACTIVITIES

(Sec. 207 of the bill)

Problem

Both the General Accounting Office and the HEW Audit Agency have found substantial unnecessary and overutilization of costly institutional care under medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care. There is no provision in present law which places affirmative responsibility upon States to assure proper patient placement. As a practical matter, the Department of HEW has seldom if ever, recovered from a State amounts improperly spent for non-covered care or services.

House Bill

1. Unless a State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization of nursing home care, effective January 1, 1973, the House bill provides for a one-third reduction in the Federal medicaid matching share for stays in a fiscal year which exceed 60 days in a skilled nursing home.

2. Federal matching would be available, in any year, for only: (a) 60 days of care in a general or TB hospital, and (b) 90 days in a mental hospital (except that an additional 30 days would be allowed in a mental hospital if the State shows that the patient will benefit). There would be no Federal matching for care in a mental hospital beyond 120 days in any year. In addition, there would be no Federal matching for care in a mental hospital after 365 days of such care during a patient's lifetime.

3. The House bill would also provide for an increase of 25% (up to a maximum of 95%) in the Federal medicaid matching formula for amounts paid by States under contracts with Health Maintenance Organizations or other comprehensive health care facilities.

4. The bill would provide authority for the Secretary to assure that average Statewide reimbursement for intermediate care in a State is reasonably lower than average payments for higher level skilled nursing home care in that State.

Finance Committee Changes

1. In addition to the utilization review requirement, States must also conduct the independent professional audits of patients as required by present law which are intended to assure that the patient is getting the right care in the right place.

2. Where a State makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of hospital and mental hospital care: (a) the 60-day limitation in general and TB hospitals, and (b) the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals, would not apply. If proper procedures assure that the patient needs the care and is benefiting from it, it seemed inappropriate to cut off Federal matching utilizing arbitrary limitations.

3. The committee deleted the House provision calling for a 25% increase in matching for amounts paid to HMO's, since if HMO's deliver services more efficiently, and economically, it would be in the States' interest to deal with HMO's without an increase in matching.

4. Intermediate care services would also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appeared appropriate in view of the shift of intermediate care to medicaid in legislation enacted subsequent to House consideration of H.R. 1.

5. Finally, the Secretary's validation of State utilization controls would be made on site in the States and such findings would be a matter of public record. The purpose here is to assure actual—rather than paper—compliance with the proposed statutory requirements.

COST SHARING UNDER MEDICAID

(Sec. 208 of the bill)

Problem

Under present law, States may require payment by the medically indigent of premiums, deductibles and co-payment amounts with respect to medicaid services provided them but such amounts must be "reasonably related to the recipient's income." However, States cannot require cash assistance recipients to pay any deductibles or copayments.

House Bill

This section contains 3 provisions:

1. It requires States which cover the medically indigent to impose monthly premium charges. The premium would be graduated by income in accordance with standards prescribed by the Secretary and details regarding the operation of the premium would be left to the Secretary's discretion. The House Committee report indicates that it would be expected that premiums would be fixed on a state-by-state basis at whatever level would be required to result in a savings under the medically indigent program of approximately 6 percent.

2. States could, at their option, require payment by the medically indigent of deductibles and co-payment amounts which would not have to vary by level of income.

3. With respect to cash assistance recipients, nominal deductible and co-payment requirements, while prohibited for the six mandatory services required under Federal law (inpatient hospital services; outpatient hospital services; other X-ray and laboratory services; skilled nursing home services; physicians' services; and home health services), would be permitted with respect to optional medicaid services such as prescribed drugs, hearing aids, etc.

Finance Committee Changes

The provision would be modified by the committee bill as follows:

1. The House bill permits States to impose co-payments and deductibles on the medically indigent. The committee change limits such amounts to co-payments on patient-initiated elective services only, such as the initial office visits to physicians and dentists.

2. The House bill also allows States to impose co-payments and deductibles on the indigent for optional medicaid services. The committee deleted this provision, as the savings (\$5 million) would most probably be exceeded by the administrative costs.

MANDATORY MEDICAID DEDUCTIBLE FOR FAMILIES WITH EARNINGS

(Sec. 209 of the bill)

Problem

Under present law, AFDC families with earnings can, at a certain earnings point lose eligibility for medicaid. This has been called the "Medicaid Notch". This notch is believed to act as a potential work disincentive, since at a certain income level a family may precipitously lose medicaid eligibility if it has additional earnings.

House Bill

Section 209 would remove this "notch" by requiring AFDC families with earnings to pay a medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over \$720. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. This approach eliminates any sudden loss of medicaid eligibility. However, although eligible for medicaid, every dollar of a recipient's retained earnings raises his medicaid deductible by one dollar.

In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this point, however, his medicaid deductible would increase dollar for dollar with his retained earnings.

Finance Committee Changes

Although the House provision eliminates any sudden loss of eligibility for medicaid, the provision acts as a substantial work disincentive, since the medicaid deductible increases dollar for dollar with retained earnings.

In order to avoid establishing a substantial work disincentive the committee amended section 209 to deal with the "Medicaid Notch" by allowing guaranteed employment program families otherwise eligible for medicaid, who would ordinarily lose eligibility as a result of earnings from employment, to remain eligible for medicaid for one year. At the expiration of that year, such families could elect to continue in medicaid by paying a premium of 20 percent of income in excess of \$2,400 annually (excluding work bonus amounts). Additionally, other families participating in the guaranteed employment program (see title IV) which are otherwise ineligible for medicaid in a State could also voluntarily elect to participate by paying a premium of 20

percent of income (excluding work bonus) above \$2,400. Costs of coverage for those families on a premium basis would be subsidized by the Federal Government to the extent premium income did not cover the costs of benefits for those families.

The committee retained that portion of section 209 of the House bill which gives States the option of covering under medicaid aged, blind and disabled persons made newly eligible as a result of the increases in payment levels to these persons proposed by the committee.

MEDICARE BENEFITS FOR BORDER RESIDENTS

(Sec. 211 of the bill)

Problem

At present, coverage for care in a foreign hospital near the U.S. border is available only where an emergency occurs *within* the United States and where the foreign institution is the closest adequate facility. This limitation creates difficulty in securing necessary non-emergency care by border residents who ordinarily do and would use the nearest hospital suited to their medical needs, which may be a foreign hospital.

House Bill

Authorizes use of a foreign hospital by a U.S. resident where such hospital was closer to his residence or more accessible than the nearest suitable United States hospital. Such hospitals must be approved under an appropriate hospital approval program.

In addition, the provision authorizes part B payments for necessary physicians' services furnished in conjunction with such hospitalization.

Finance Committee Changes

The committee approved the House provisions; it also authorized medicare payments for emergency hospital and physician services needed by beneficiaries in transit between Alaska and the other continental States.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

(Sec. 226 of the bill)

Problem

Certain large medical care organizations seem to make the delivery of medical care more efficient and economical than the medical care community at large.

Medicare does not currently pay these comprehensive programs on an incentive capitation basis, and consequently any financial incentives to economical operation in such programs have not been incorporated in medicare.

Two areas of potential concern arise in dealing with HMO's. The first area of concern involves the quality of care which the HMO's will deliver. Most existing large HMO's provide care which is generally accepted as being of professional quality. However, if the Government begins on a widespread basis, to pay a set sum in advance to an organization in return for the delivery of all necessary care to a group of people, there must be effective means of assuring that such

organization will not be tempted to cut corners on the quality of its care (e.g., by using marginal facilities or by not providing necessary care and services) in order to maximize its return or "profit." Under present reimbursement arrangements, although there may be no incentive for efficiency, neither is there an incentive to profit through underservicing and other corner-cutting.

The second problem area involves the reimbursement of HMO's. If an HMO were to enroll relatively good risks (i.e., the younger and healthier medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large "windfalls" for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO.

House Bill

The House bill authorizes medicare to make a single combined parts A and B payment, prospectively on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present parts A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing pre-paid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Finance Committee Changes

Agreeing with the desirability of authorizing reasonable per capita payments to organizations which have demonstrated a capacity to provide quality health care, and recognizing the above problems, the committee authorized the following approach as a modification of the HMO provision in the house bill :

Eligibility

The Secretary would be authorized to contract on an incentive capitation basis for medicare services with substantial, established HMO's: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined part A-part B capitation rate. Such reimbursement would be authorized for HMO's which: (1) have been in operation for at least two years, and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over. The

Secretary would be authorized to make exceptions to the minimum enrollment requirement in the case of HMO's in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation capacity to provide health care services of proper quality on a prepaid basis and which have at least 5,000 members.

Reimbursement

The combined part A-part B per capita payment would be determined and administered as follows:

1. An eligible HMO approved by the Secretary for per capita reimbursement would submit, at least 90 days prior to the beginning of a prospective medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding medicare costs in the HMO's area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost" (as defined below).

2. At the beginning of the contract period, the HMO would be paid monthly, in advance, the interim per capita prepayment for the medicare beneficiaries actually enrolled. The HMO would submit interim cost estimates on a quarterly basis and the interim payment could be adjusted as indicated in such estimates, subject however to the limitations set forth below.

3. The HMO would submit, annually, independently certified financial statements, including certified costs statements allocating HMO operating costs to the medicare population in proportion to utilization of HMO resources. Allocations may use statistical, demographic and utilization data collection and analysis methods acceptable to the Secretary in lieu of fee-for-service or cost-per-service methods in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance with medicare accounting principles but not necessarily on the basis of actual case-by-case patient services. All HMO's would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General (and the Inspector General for Health Care administration).

4. The Secretary would retroactively determine on an actuarial basis what the per capita costs for part A and part B services for the HMO's medicare population would have been if the population had been served through other health care arrangements in the same general area and not enrolled in the HMO. That is to say there would be a calculation, on the basis of experience in the same or similar geographical areas, of the cost for the non-HMO group of similar size, age distribution, sex, race, institutional status, disability status, cost experience for the medicare contract year in question, and other factors deemed by the actuaries to be relevant and material. This figure defined as "adjusted average per capita cost" would be determined as promptly as practical after the end of a contract period. Many of the difficulties and uncertainties of previously suggested methods of

rate determination are minimized or eliminated by making this determination after the fact. For example, the makeup of the enrolled population and medicare cost experiences—within and outside of the HMO—would be known, rather than merely estimated.

5. If the HMO's costs for the types of expenses reimbursable under medicare are less than the adjusted average per capita cost the difference, called "net savings" would be divided and allocated as follows:

Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 percent and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80 percent level would be allocated entirely to the Government.

Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would receive a share equal to $7\frac{1}{2}$ percent of the adjusted average per capita costs and the Government would retain $12\frac{1}{2}$ percent of those costs.

6. At the option of the HMO, it could apply any amount of its share of the saving toward improved benefits, reduced supplemental premium rates, or other advantages for beneficiaries or retain the money. It could not, however, make cash refunds to beneficiaries.

7. If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would be allocated between the Government and the HMO in the following manner:

Any amount of excess between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 25 percent by the HMO and 75 percent by the Government. Costs in excess of 120 percent would be borne entirely by the Government. Any losses incurred would carry forward and be recovered, proportionally, by the HMO and the Government in the future. Any losses by the Government would have to be recovered in full before any "savings" could be paid to an HMO in future years.

REPEAL OF SECTION 1902(d) OF MEDICAID

(Sec. 231 of the bill)

Problem

The medicaid program has been a significant burden on State finances. In an effort to reduce financial pressure upon States, Section 1902(d) of title 19 provides that a State may reduce the range, duration or frequency of the services it provides under its medicaid program, but it cannot reduce its aggregate expenditures for medicaid from one year to the next. This maintenance of effort requirement has forced a few States to either cut back on other programs or to consider dropping medicaid.

House Bill

The House bill provides for a continuance of the maintenance of effort clause with respect to the six mandatory health care services. The provision would, however, amend section 1902(d) by restricting the maintenance of effort requirement to those six basic services. The State would be able to modify the scope, extent and expenditures for optional services provided, such as drugs, dental care and eyeglasses.

Finance Committee Changes

The committee substituted for the House provision an amendment repealing sec. 1902(d)—entirely. This action is consistent with committee and Senate action on H.R. 17550 in 1970.

PAYMENTS TO STATES UNDER MEDICAID FOR DEVELOPMENT OF COST
DETERMINATION SYSTEMS FOR STATE-OWNED GENERAL HOSPITALS

(Sec. 235 of the bill)

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their medicaid programs and do not possess the financial and technical resources to develop them. Their recourse today is to contract with private companies for their data processing.

House Bill

1. Authorizes 90 percent Federal matching payments toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

2. Authorizes 90% matching for 2 years (up to a total of \$150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Finance Committee Changes

The committee deleted the first part of the House provision retaining, however, the part authorizing funds for cost-determination systems.

PROVIDER REIMBURSEMENT REVIEW BOARD

(Sec. 243 of the bill)

Problem

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 administrative procedures exist to assist providers and intermediaries to reach reasonable settlement on disputed items.

House Bill

The House bill establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is \$10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

The House provision is similar to a Senate amendment to H.R. 17550 in 1970. The House did not include those portions of the earlier Senate amendment which would allow providers, as a group, to appeal aggregate amounts of \$10,000 on a common issue; and which would

allow appeals to the Board by a provider where the intermediary fails to make timely final costs determinations.

Finance Committee Changes

The committee substituted the 1970 Senate language and added language requiring the Secretary to report to the legislative committees at the end of the first year of operation of the provision concerning its capacity to function effectively and equitably as well as any suggestions he might have for improvement of the process.

PHYSICAL THERAPY SERVICES AND OTHER SERVICES UNDER MEDICARE

(Sec. 251 of the bill)

Problem

Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office.

An additional problem relating to physical therapy is that a patient can exhaust his inpatient benefits and continue to receive payment for treatment *only* if the facility can arrange with another facility to furnish the therapy as an outpatient service. For example, a hospitalized patient would receive necessary physical therapy as a part A benefit during his 90 days of coverage. But, if his hospital stay exceeded 90 days, he would be required to secure such services under part B as an outpatient of another participating provider—even though the hospital, itself, was capable of providing the needed therapy conveniently.

Another problem is the rapidly increasing cost of physical therapy services and findings of abuse of the benefit.

House Bill

The House bill would include as covered services under part B, physical therapy provided in the therapist's office under such licensing as the Secretary may require and pursuant to a physician's written plan of treatment.

It would also authorize a hospital or extended care facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his part B benefits after his inpatient benefits have expired.

Finally, it would control physical therapy costs by limiting total payments in one year for services by an independent practitioner in his office or the patient's home to \$100, and by limiting reimbursement for services provided by physical and other therapists to a reasonable salary-related basis rather than fee-for-service basis.

Finance Committee Changes

The committee modified the House provision by adopting language to assure that factors, such as traveltime, be included in the calculation of salary-related reimbursement and deleting the provision that would have established a new and separate benefit of up to \$100 annually for services provided by an independent physical therapist in his office or in a patient's home.

Additionally, the committee will include in its report instructions to the Secretary designed to assure that reasonable arrangements may be undertaken in rural and smaller population centers to enhance availability of physical therapy in those areas.

WAIVER OF REGISTERED NURSE IN RURAL SKILLED NURSING FACILITY

(Sec. 267 of the bill)

Problem

There are some rural nursing homes which can obtain a registered nurse to work one shift 5 days a week, but which are unable to obtain the services of an additional registered nurse to work on the other 2 days, generally the weekend.

House Bill

The House bill would allow a complete waiver of the requirement for a registered nurse in a rural nursing home, if there is no other skilled nursing home in the area to meet patient needs. Under the bill a skilled nursing home could function without any skilled nurse at all.

Finance Committee Changes

The committee modified the provision granting waivers for certain rural skilled nursing facilities which are unable to assure the presence of a full-time registered nurse in such facilities 7 days a week. The committee modification would allow a rural skilled nursing home, which has one full-time registered nurse and is making good faith efforts to obtain another, a special waiver of the nursing requirement with respect to not more than two shifts, such as over a weekend. This special waiver would be authorized if the facility had only patients whose physicians indicated that each such patient could be without a registered nurse's services for a 48-hour period. If the facility had any patients for whom physicians had indicated a need for daily skilled nursing services, the facility would have to make arrangements for a registered nurse or a physician to spend such time as was necessary at the facility on the uncovered day to provide the skilled services needed.

COVERAGE OF CHIROPRACTIC SERVICES

(Sec. 273 of the bill)

Problem

Chiropractors are not currently eligible to participate as physicians in the medicare program.

House Bill

The House bill calls for a study regarding the coverage of chiropractors.

Finance Committee Changes

The Committee on Finance deleted the study of chiropractic services called for in the House bill and substituted a provision providing for the coverage under medicare of services involving treatment by means of manual manipulation of the spine by a licensed chiropractor who meets certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiro-

practic services applicable to medicare would also pertain to States providing such care under medicaid.

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

ESTABLISHMENT OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

(Sec. 249F of the bill)

Problem

There are substantial indications that a significant amount of health services paid for by medicare and medicaid are in excess of those which would be found to be medically necessary under appropriate professional standards. Furthermore, in some instances services provided are of unsatisfactory professional quality.

Finance Committee Amendment

The committee provided for the establishment of Professional Standards Review Organizations sponsored by organizations representing substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and on-going review of services covered under the medicare and medicaid programs. The purpose of the amendment would be to assure proper utilization of care and services provided in medicare and medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption in carrying out the important review activities in the two highly expensive programs. The amendment provides discretion for recognition of and use by the PSRO of effective utilization review committees in hospitals and medical organizations.

COVERAGE OF CERTAIN PRESCRIBED DRUGS UNDER MEDICARE

(Sec. 215 of the bill)

Problem

The costs of outpatient prescription drugs represent a major item of medical expense for many older people, especially for those suffering from chronic and serious illness conditions. The costs of such drugs are not presently covered under the medicare program.

Finance Committee Amendment

The committee amended part A of medicare to cover the costs of certain specified drugs, purchased on an outpatient basis, which are necessary in the treatment of the most common, crippling or life-threatening chronic disease conditions of the aged. Beneficiaries would pay \$1 toward the cost of each prescribed drug included in the reasonable cost range for the drug involved.

The amendment would cover specific drugs used in the treatment of the following conditions: arthritis, cancer, chronic cardiovascular disease, chronic kidney disease, chronic respiratory disease, diabetes, epilepsy, gout, glaucoma, high blood pressure, myasthenia gravis, Parkinson's disease, rheumatism, thyroid disease and tuberculosis. The amendment would limit reimbursement to certain drugs used in the

treatment of these conditions. For example, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anti-coagulant drugs to reduce the danger of blood clots and drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs which would be used by people without heart conditions.

Other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment, much more difficult to handle administratively, and many patients without chronic heart disease may also utilize these types of medications.

The major provisions of the amendment are:

Eligibility.—Medicare beneficiaries with one or more of the following conditions:

- Diabetes.
- High blood pressure.
- Chronic cardiovascular disease.
- Chronic respiratory disease.
- Chronic kidney disease.
- Arthritis, gout and rheumatism.
- Tuberculosis.
- Glaucoma.
- Thyroid disease.
- Cancer.
- Epilepsy.
- Parkinsonism.
- Myasthenia gravis.

Benefits.—Would include those drugs:

Necessary over a prolonged period of time for treatment of the above conditions;

Generally subject to use only by those with the above conditions.

This recommendation would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used only for a short period of time, and drugs such as tranquilizers and sedatives which may be used by eligible beneficiaries but also by many other persons.

A list of the covered drug categories and illustrative drug entities follows:

THERAPEUTIC CATEGORY AND DRUG ENTITY

- Adrenocorticoids
- Anti-anginals
- Anti-arrhythmics
- Anti-coagulants
- Anti-convulsants (excluding phenobarbital)
- Anti-hypertensives
- Anti-neoplastics
- Anti-Parkinsonism agents

Anti-rheumatics
 Bronchodilators
 Cardiotonics
 Cholinesterase inhibitors
 Diuretics
 Gout suppressants
 Hypoglycemics
 Miotics
 Thyroid hormones
 Tuberculostatics

Reimbursement and Cost Controls.—The amendment would utilize a reasonable allowance reimbursement method, and would incorporate a formulary approach. The formulary established could include only drug entities in categories specified above. Participating pharmacies would file either their customary professional fee or other dispensing charges as of June 1, 1972, which would then be applied to the acquisition cost (generally, average wholesale price) up to a level (determined by the Secretary of HEW on the basis of the lower cost products of a given drug available and sold to pharmacies) of the drug product. The professional fee, or other dispensing charges, for purposes of program payments and allowances, could not exceed the 75th percentile of mark-ups or fees by comparable vendors in an area. Out-patient drugs dispensed by a participating hospital or extended care facility would be reimbursed on the regular part A medicare costs basis. Increases in prevailing fees or dispensing charges could be accepted by the Secretary of HEW in a fashion essentially parallel to that applicable to physicians' fees.

Financing.—Part A medicare payroll tax.

Cost.—\$740 million with a \$1 co-payment per prescription. There would be an offsetting reduction in Federal-State medicaid costs of some \$100 million as a result of this medicare drug coverage.

INSPECTOR GENERAL FOR MEDICARE AND MEDICAID

(Sec. 216 of the bill)

Problem

There is, at present, no independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of medicare and medicaid in terms of the efficiency and effectiveness of program operations and compliance with congressional intent. While HEW's Audit Agency and the General Accounting Office have done helpful work, there is a need for day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

Finance Committee Amendment

Under the amendment, an Office of Inspector General for Health Administration would be established within the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the Social Security health pro-

grams on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the statute and congressional intent.

The Inspector General would be authorized to issue an order of suspension of a formal regulation, practice, or procedure which he found inconsistent with the law or legislative intent. Generally speaking, such suspension would become effective not less than 30 days after issuance unless specifically countermanded by the Secretary of HEW. Upon issuance of an order of suspension the Inspector General would be required to immediately advise the committees on Finance and Ways and Means as to the findings and basis for the order. If the Secretary countermands, he too would be required to immediately advise the legislative committees as to the reasons for his action. Thus, a serious issue involving a question concerning congressional intent would be placed before the committees having jurisdiction in orderly and delineated fashion.

MEDICAID COVERAGE OF MENTALLY ILL CHILDREN

(Sec. 229B of the bill)

Problem

Present law limits reimbursement under medicaid for care of the mentally ill to those otherwise eligible individuals who are 65 years of age or older.

Finance Committee Amendment

The committee bill would authorize coverage of inpatient care in mental institutions for medicaid eligibles under age 21, provided that the care consists of a program of active treatment, that it is provided in an accredited medical institution, and that the State maintains its own level of fiscal expenditures for care of the mentally ill under 21.

The amendment also provided for demonstration projects of the potential benefits of extending medicaid mental hospital coverage to mentally ill persons between the ages of 21 and 65.

PUBLIC DISCLOSURE OF INFORMATION REGARDING DEFICIENCIES

(Sec. 299D of the bill)

Problem

Physicians and the public are currently unaware as to which hospitals, extended care facilities, skilled nursing home and intermediate care facilities have deficiencies and which facilities fully meet the statutory and regulatory requirements. This operates to discourage the direction of physician, patient, and public concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Finance Committee Amendment

The committee added to the House bill a provision under which the Secretary of Health, Education, and Welfare would be required to make reports of an institution's significant deficiencies or the absence thereof (such as deficiencies in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available at social security district offices. Following completion of a survey of a health care facility or organization, those portions of the survey re-

lating to statutory requirements as well as those additional significant survey aspects required by regulation relating to the capacity of the facility to provide proper care in a safe setting would be matters of public record. In the case of medicare, such information would be available for inspection within 90 days of completion of the survey upon request in Social Security District Offices, and, in the case of medicaid, the information would be available in local welfare offices.

EXTENDED CARE FACILITIES—SKILLED NURSING FACILITIES

(Secs. 246, 247, 248, 249 249A and 278 of the bill)

Problem

Serious problems have arisen with respect to the skilled nursing home benefit under medicaid and the extended care benefit under medicare.

In the case of medicare, the definition of eligibility has been extremely difficult to apply objectively and, consequently, has led to great dissatisfaction on the part of patients, providers and practitioners, resulting in many facilities' refusal to participate in medicare and widespread retroactive denial of benefits.

Medicaid has its own set of problems with respect to skilled nursing home care. These include, according to the General Accounting Office and the HEW Audit Agency, widespread inappropriate placement of patients in skilled nursing homes who more properly belong in other institutional settings—such as intermediate care facilities—and widespread noncompliance with required standards. It appears difficult to insist that a skilled nursing facility meet all necessary standards without, at the same time, assuring that reimbursement is equitable for necessary care in the proper setting. In general, that is not the case today. The Comptroller General and others have reported on the often irrational payment mechanisms developed and utilized by many States in reimbursing for nursing home care. On an aggregate basis, it appears that nursing homes are not underpaid. However, because of the arbitrary payment structures in many States, in all probability, many facilities are being overpaid for the care they provide while others are being underpaid.

Finance Committee Amendments

a. *Conforming Standards for Extended Care and Skilled Nursing Home Facilities.*—The committee bill would establish a single definition and set of standards for extended care facilities under medicare and skilled nursing homes under medicaid. The provision creates a single category of "skilled nursing facilities" which would be eligible to participate in both health care programs. A "skilled nursing facility" would be defined as an institution meeting the present definition of an extended care facility and which also satisfies certain other medicaid requirements set forth in the Social Security Act. These changes are intended to reduce duplicative activity and redtape.

b. *"Skilled Care" Definition for Extended Care.*—To make the medicare extended-care benefit more equitable and suitable to the post-hospital needs of older citizens, as well as to avoid the problem of retroactive denials of coverage which have plagued medicare patients and facilities, the committee bill would change the definition of care requirements with respect to entitlement for extended care benefits

under medicare. Present law would be amended to authorize skilled care benefits for individuals in need of "skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." Medicare coverage would also continue during short-term periods (e.g. a day or two) when no skilled services were actually provided but when discharge from a skilled facility for such brief period was neither desirable nor practical.

c. *14-Day Transfer Requirement for Extended Care Benefits.*—Under existing law, medicare beneficiaries are entitled to extended care benefits only if they are transferred to an extended care facility within 14 days following discharge from a hospital. The committee modified this with respect to certain patients. An interval of more than 14 days would be authorized for patients whose conditions did not permit immediate provision of skilled services within the 14-day limitation (e.g., patients with fractured hips whose fractures have not mended to the point where physical therapy and restorative nursing can be utilized). An extension not to exceed 2 weeks beyond the 14 days would also be authorized in those instances where an admission to an ECF is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area.

d. *Reimbursement Rates for Care in Skilled Nursing Facilities.*—The committee added a provision amending title 19 to require States, by July 1, 1974, to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary found to be acceptable for a State's medicaid program would be adapted, with appropriate adjustments, for purposes of medicare skilled nursing facility reimbursement in that State.

e. *Skilled Nursing Facility Certification Procedures.*—The committee also added a provision under which the Secretary of HEW would decide whether a facility qualifies to participate as a "skilled nursing facility" in both the medicare and medicaid programs. The Secretary would make that determination, based principally upon the appropriate State health agency evaluation of the facilities. A State could, for good cause, decline to accept as a participant in the medicaid program a facility certified by the Secretary but could not overrule the Secretary and receive Federal medicaid matching funds for any institution not approved by the Secretary. The committee also incorporated into the amendment proposals of the President regarding full Federal financing of skilled nursing facility and intermediate care facility survey and inspection costs attributable to the medicare and medicaid program and the training of additional Federal and State nursing facility inspection personnel.

AUTHORITY FOR DEMONSTRATION PROJECTS CONCERNING THE MOST
SUITABLE TYPES OF CARE FOR BENEFICIARIES READY FOR DISCHARGE
FROM A HOSPITAL OR SKILLED FACILITY

(Sec. 222 of the bill)

Problem

It is not unusual for a previously hospitalized medicare beneficiary to need services other than those covered under the program. A bene-

ficiary who is discharged from a hospital may need further institutional care for a condition for which he was hospitalized, but the care required is not skilled care.

Finance Committee Amendment

The committee bill authorizes the Secretary of HEW to experiment with methods for determining suitable levels of care for medicare patients who are ready for discharge from hospitals and skilled nursing facilities and no longer require skilled care, including some terminally ill patients but who are unable to maintain themselves at home without some sort of additional assistance. The experiments and demonstration projects could include (1) making medicare payment for each day of care provided in an intermediate care facility, count as one covered day of skilled nursing facility care, if the care was for the condition for which the person was hospitalized, (2) covering the services of homemakers, where institutional services are not needed. Such experiments would be aimed at determining whether such coverage could effectively lower long-range costs by postponing or precluding the need for higher cost institutional care or by shortening the period of such care, and ascertaining what eligibility rules may be appropriate and the resultant costs of application of various eligibility requirements, if the project suggests that extension of such coverage generally, would be desirable.

PHYSICIANS' ASSISTANTS

(Sec. 222 of the bill)

Problem

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 200 experimental training programs for physician assistants and nurse practitioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while medicare does not, in some instances, recognize all their services as reimbursable items.

Under present law, part B of medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physician's office by para-medical personnel. For example, if a nurse administers an injection in the office, medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, medicare will not recognize a physician's charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home. Others argue that medicare does reimburse physicians for services provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They go on to argue that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for medicare to take the lead in encouraging doctors—by generous reimbursement to use physicians' assistants to work independently or to expand their responsibilities.

Finance Committee Amendment

The committee authorized demonstration projects to determine the most appropriate and equitable methods of compensating for the services of physicians' assistants (including nurse practitioners). The objectives are development of non-inflationary and less-costly alternatives which do not impede the continuing efforts to expand the supply of qualified physicians' assistants.

THE ROLE OF THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS IN MEDICARE

(Sec. 244 of the bill)

Problem

Several problems have arisen with respect to the JCAH role in the medicare certification process. Present law specifies that an institution may be deemed to meet the certification requirements of medicare if it is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In addition, under the definition of a hospital, the section states that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. Another section of the law does allow an individual State to set higher standards.

The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to the commission and the facility concerned. Consequently, the Federal agencies responsible to the Congress for the administration of medicare, are not in a position to audit the validity of the overall JCAH survey process and are thus unable to determine the extent to which specific deficiencies may exist in the vast majority of participating hospitals, since JCAH survey reports are not available to the Social Security Administration. A further problem arises because, under present law, medicare is barred from setting

any standards which are higher than comparable JCAH requirements. This has been interpreted by Social Security to also bar establishment of any standards in an area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves as an almost total and blanket delegation of authority over hospital standards to a private agency. Thus, if the Joint Commission chooses to lower a standard, medicare is obliged to also accept that reduced standard. Though the Federal Government is tied to JCAH standards, a State may promulgate higher standards for facilities within the State.

Finance Committee Amendment

The committee approved a provision under which the State certification agencies, as directed by the Secretary, would survey on a selective sample basis (or where substantial allegations of noncompliance have been made) hospitals accredited by the Joint Commission on Accreditation of Hospitals. This would serve as a mechanism to validate the JCAH survey process. If deficiencies from the JCAH standards were found to exist in an institution, the medicare standards and compliance procedures would be applied in that facility. To implement this authority, JCAH hospitals would, as a condition of participating in medicare, agree, if included in a survey, to authorize the State agency or the Secretary to secure copies of the JCAH survey report on a confidential basis. The Joint Commission on Accreditation of Hospitals has indicated that it would cooperate fully with such validation surveys and the Secretary would be expected to consult with and cooperate with JCAH in these activities.

Under the provision the Secretary would be authorized to promulgate standards as necessary for health and safety after consultation with JCAH and with adequate lead-time without being bound to JCAH standards.

MATERNAL AND CHILD HEALTH

(Sec. 291 of the bill)

Problem

The intent of the 1967 Social Security Amendments with respect to the Maternal and Child Health programs was to divide available funds between formula grants to the States, and special project grants for a few years, so that the Federal Government could fund innovative special project grants which the States might not be able to support out of their formula funds. The 1967 Amendments terminated special project grants as of fiscal year 1973 and converted all the project money to formula grants on the rationale that after a few years' time the States would recognize the value of and continue to support worthwhile project grants as part of an overall State program. Two problems have occurred in the interim. First the special project grant has been utilized primarily in urban ghetto areas, while the formula funds are weighted in favor of rural States. Therefore, a shift of funds from urban States with project grants to rural States without project grants would occur if the project grants were terminated. Additionally, many project grant directors feel that with the pressure on State finances, State health departments would be reluctant to use new formula funds to continue support for project grants however worthy they might be.

Recognizing the problem, Congress has approved an extension of the project grant authority to June 30, 1973.

Finance Committee Amendment

The committee added to H.R. 1 a provision which extends for an additional fiscal year (through June 30, 1974) the present special project grant authorization contained in title V of the Social Security Act to support maternal and child health programs. This approach allows 2 years for completion of comprehensive evaluation of the efficacy of the project grant approach in relation to formula grants as well as to assess the effectiveness and success of the various grants. The 2-year period also permits orderly budgeting by grantees.

CONDITIONS OF COVERAGE OF SPEECH PATHOLOGISTS AND CLINICAL PSYCHOLOGISTS UNDER MEDICARE

(Secs. 283 and 284 of the bill)

Problem

While speech pathology and clinical psychology services are at times useful to aged persons with certain disorders, such services are relatively inaccessible to the aged due to the small percentage of speech pathologists who are employed by providers eligible to participate in the medicare program. Part of the problem is the fact that when such services are not furnished by a medicare provider, they must be furnished under direct physician supervision to be covered under medicare.

Finance Committee Amendment

Coverage of the services of clinical psychologists and speech therapists on an outpatient basis is presently available under medicare if the services of such personnel are rendered in a physician-directed clinic or hospital outpatient department. The committee included a provision removing the requirement that such care necessarily be rendered in a *physician-directed* clinic or outpatient department. However, the services would still have to be provided in an organized setting, and under a plan of care and treatment established by a physician who would retain overall responsibility for the patient's care. Additionally, with respect to psychological treatment, such costs would be included in and limited by the overall \$250 annual limitation on reimbursement for outpatient treatment of mental illnesses.

PROVIDE SECRETARY GREATER DISCRETION IN SELECTION OF INTERMEDIARIES AND ASSIGNMENT OF PROVIDERS TO THEM

(Sec. 286 of the bill)

Problem

A group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization (including the Federal Government) to act as the "fiscal intermediary" between the providers and the Government. (No such nomination is available with respect to carriers in part B of medicare.)

The Secretary is authorized to enter into an agreement with an organization or agency only if he finds that to do so would be con-

sistent with effective and efficient administration of the program. The Secretary may terminate an agreement with an intermediary if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

It would be helpful to strengthen administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers. The Secretary should have the primary authority to determine to which intermediary providers may be reassigned when they wish to change intermediaries or where continued availability of a particular intermediary in a given locale is inefficient, ineffective, or otherwise not in the best program interest. That is, the Secretary should consider the wish of the provider, but be able to take a different course of action in the interest of effective program operation.

Finance Committee Amendment

The Finance Committee amended section 1816 so as to authorize the Secretary to assign and reassign providers to available intermediaries. He would take into account any preferences expressed by the providers, but would not be bound by their choice. The primary consideration for his assignment action would be the effective and efficient administration of the medicare program.

DISCLOSURE OF INFORMATION CONCERNING MEDICARE AGENTS AND PROVIDERS

(Sec. 249C of the bill)

Problem

As part of its responsibility for administration of the medicare program, the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers and intermediaries—and State agencies, which assist SSA in program administration. In addition, SSA also prepares program validation review reports, which are intended to be used as management devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own medicare operations.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual contractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The Finance Committee recognized the dichotomy which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractor performance with the accompanying pressures for improvement in administration that only such awareness can bring. On the other hand, there is the need to avoid premature public disclosure of this type of information and to provide contractors with sufficient opportunity to respond to the information in the reports before their publication to avoid release of erroneous findings, without rebuttal, which may prove damaging to their reputations.

Finance Committee Amendment

To meet this problem, the Committee amendment provides that the SSA regularly make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals deleted.

The proposal would require public disclosure of future reports. Such reports would include only those which are official in nature and not include internal working documents such as informal memoranda, etc. Under the proposal, public disclosure of evaluations and reports would not be made until the contractor, State agency, or facility was given suitable opportunity for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment.

Disclosure of such evaluations and reports should not lessen the effort of SSA in its present information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting disclosure of information required under the Freedom of Information Act.

**PROTECTING AGED, BLIND, AND DISABLED WELFARE RECIPIENTS FROM
LOSS OF MEDICAID ELIGIBILITY**

(Sec. 249D of the bill)

The Committee approved an amendment to assure that aged, blind, and disabled welfare recipients who are currently eligible for Medicaid will not lose their eligibility for Medicaid benefits solely because of the recent 20-percent social security benefit increase. The amendment will assure that about 180,000 aged, blind, and disabled welfare recipients will not lose this valuable protection.

**PROHIBITION AGAINST INSTITUTIONAL MEDICAL CARE PAYMENTS UNDER
CASH WELFARE PROGRAMS**

(Sec. 249E of the bill)

Under present law, States can purchase medical care for welfare recipients either through medicaid vendor payments to providers or by including the cost of the medical services in calculating the cash welfare payment to the recipient.

The committee was concerned that as the Department of Health, Education and Welfare steps up its enforcement of standards which medicaid institutions must meet, situations might occur in which substandard skilled nursing facilities and intermediate care facilities would avoid meeting medicaid standards of fire safety, sanitation, and quality of care by withdrawing from the medicaid program and instead continuing support of patients in the homes through adding the cost of their care to the patients' monthly welfare payments.

To prevent possible utilization of substandard facilities through the cash payment mechanism, the committee approved an amendment which would preclude Federal matching for that portion of any money payment which is related to institutional medical or remedial care which could be included under the medicaid program.

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS
ARE DISALLOWED

(Sec. 213 of the bill)

Problem

Under present law, whenever a medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary. This is true even when the program has paid the claim and subsequently it is determined that the claim should be reopened and disallowed. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

Finance Committee Amendment

Under the committee bill, a beneficiary could be "held harmless" in certain situations where claims were disallowed but the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether, for example, the provider utilized due care (i.e., acted reasonably) in applying medicare policy in his dealings with the beneficiary and the Government. In the future, Professional Standards Review Organizations would be expected to give priority to determinations, either advance or concurrent, designed to minimize the problem of retroactive denials.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the medicare appeals process.

Where neither the beneficiary nor the provider knew that non-covered services were involved, the Government would assume liability for payment as though a covered service had been furnished. (This situation would arise in many cases disallowed because the services were not medically necessary or did not meet the level of care requirements.) However, when medicare made such a payment, it would make certain that the provider is put on notice that the type of service rendered was not covered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case, he could not contend that he exercised due care. Thus, the Government's liability would be somewhat limited.

Where the provider did not exercise due care (that is, he knew or reasonably could be expected to know that such care was not covered), liability would shift to the provider, assuming that there was good faith on the beneficiary's part. The provider would be told that he could appeal the intermediary's decision, both as to coverage of the

services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the medicare program would indemnify the beneficiary (subject to deductibles and coinsurance) and would be required to seek to recover amounts so paid from the provider.

FAMILY PLANNING

(Sec. 299E of the bill)

Problem

Though Federal law and policy permit and encourage States to extend services to low income families likely to become welfare recipients as well as families already on welfare, most States have not taken advantage of this opportunity.

The progress which has been made under the 1967 Amendments has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that *all* appropriate AFDC recipients be provided family planning services has not been fulfilled.

Finance Committee Amendment

The committee amended the House bill to authorize 100 percent Federal funding for the costs of family planning services. The Committee amendment would also require States to make available on a voluntary and confidential basis such counseling, services, and supplies, directly and/or on a contract basis with family planning organizations throughout the State, to present, former or likely recipients who are of child-bearing age desiring such services. The amendment would also reduce the Federal share of AFDC funds by 2 percent, beginning in fiscal year 1974, if a State in the prior year fails to inform the adults in AFDC families and on workfare of the availability of family planning services and/or if the State fails to actually provide or arrange for such services for persons desiring to receive them.

PENALTY FOR FAILURE TO PROVIDE REQUIRED HEALTH CARE SCREENING

(Sec. 299F of the bill)

Problem

Many States have failed to implement the statutory requirement—or have implemented it only partially—because of their contention that the screening of all children under age 21 is not possible given available financial and health care resources. Under HEW regulations States must now provide health care screening to children under age 6, and States will be required to provide screening services to all eligible children between the ages of 7 and 21 by no later than July 1, 1973.

Finance Committee Amendment

The amendment also includes a provision that would reduce the Federal share of AFDC matching funds by 2 percent, beginning in fiscal year 1975, if a State, (a) fails to inform the adults in AFDC families and on workfare of the availability of child health screening services; (b) fails to actually provide or arrange

for such services; or (c) fails to arrange for or refer to appropriate corrective treatment children disclosed by such screening as suffering illness or impairment.

COVERAGE OF OUTPATIENT REHABILITATION SERVICES UNDER MEDICARE

(Sec. 285 of the bill)

Problem

Medicare beneficiaries who are not inpatients of hospitals or extended care facilities, or homebound and entitled to home health services, have limited access to certain restorative and rehabilitative services. While part B of Medicare presently covers outpatient physical therapy services furnished by providers of services including clinics, rehabilitation agencies, and public health agencies, similar coverage is not provided for other rehabilitation services which are useful to older people.

Finance Committee Amendment

The Committee included a provision establishing a new benefit category which would permit reimbursement under part B for outpatient rehabilitation furnished in organized settings. The requirements that organizations must meet in order to provide the new outpatient rehabilitation benefit would be similar to the types of standards now imposed on providers of outpatient physical therapy services. These requirements are intended to assure that only health care of proper quality will be paid for.

The new benefit would cover physical therapy, speech pathology, occupational therapy, and medical social services provided on an outpatient basis by qualified outpatient rehabilitation facilities. A physician would have to certify that the services are required by an individual who needs physical therapy or speech pathology services, and the services must be furnished in accordance with a plan established and periodically reviewed by a physician. The plan would have to prescribe the specific types of rehabilitation services to be provided and the amount and duration of such services.

MEDICARE COVERAGE FOR SPOUSES AND SOCIAL SECURITY BENEFICIARIES UNDER AGE 65

(Sec. 214 of the bill)

Present Law

Under present law, persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs are entitled to hospital insurance (part A). Essentially all persons aged 65 and over are eligible to enroll for medical insurance (part B) without regard to insured status. The House bill includes a provision that would permit persons aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A, at a premium rate equal to the full cost of their hospital insurance protection (\$33 a month through June 1974).

Problem

Many additional social security cash beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. This is particularly true if they are of an advanced age, say, age 60-64. Frequently, these older beneficiaries—retired workers, widows, mothers, dependents, parents for example—have been dependent upon their own group coverage or that of a related worker who is now deceased for health insurance protection. It is a difficult task for such older persons to find comparable protection when they no longer are connected to the labor force.

Finance Committee Amendment

The provision makes medicare protection available at cost to spouses aged 60-64 of medicare beneficiaries and to other persons aged 60-64 (such as a beneficiary who elects early retirement at age 62) entitled to benefits under the Social Security or Railroad Retirement Acts.

ALCOHOLISM AND ADDICTION

(Sec. 299G of the bill)

Problem

Under the House bill, alcoholics and addicts would be defined as disabled (applying the general social security definition of disability) for purposes of welfare eligibility. However, alcoholics and addicts would not receive cash assistance if treatment were available which they refused.

The committee was concerned that this provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or only nominally involved—in treatment programs.

Finance Committee Amendment

The committee approved an amendment establishing a program designed to encourage appropriate care and treatment of alcoholics and addicts. Below is a brief outline of the program:

Persons medically determined (as described below) to be alcoholics and addicts would not be eligible for benefits as disabled under the Supplemental Security Income program.

Alcoholics and addicts who meet the income and resources test for benefits under the new supplemental security income program established by the bill and who meet a definition of disability parallel to the social security definition—that is who are unable to engage in any substantial gainful activity by reason of a medically determinable addictive dependence on alcohol or drugs which has lasted or can be expected to last for a period of 12 months—would be eligible to receive help in an alcoholism or addiction treatment program which would be established under title XV if the State wishes to institute such a program. Once enrolled in the treatment program, the alcoholic or addict would be referred to a local treatment organization or agency certified by the appropriate State agency designated under the Comprehensive Alcohol Abuse and Treatment Act of 1970 or the Drug Abuse and Treatment Act of 1972.

In a State which provides payments under categories other than on the basis of disability to persons medically determined to be alcoholics or addicts (for example, an alcoholic mother or an addicted child on AFDC) the person must be referred for care and treatment to the appropriate agency. Refusal of care and treatment by an addict or alcoholic would result in termination of payments for that individual.

To be eligible for reimbursement under title XV, the individual treatment program must be carried out under a professionally developed plan of rehabilitation designed to terminate dysfunctional dependency on alcohol or drugs and which must be renewed at three-month intervals. Additionally, the plan must include to the maximum extent feasible a program of work experience.

In those cases where proper treatment or rehabilitation would be thwarted by the lack of maintenance funds for the enrolled alcoholic or addict, protective payments could be made with title XV funds. Maintenance payments may not exceed comparable payments under titles IV and XVI.

Matching funds under title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at medicaid rates and maintenance payments would be matched at the rates applicable to the category under which the person would otherwise be aided.

C. Financing of Social Security Trust Funds

Consistent with the policy of maintaining the social security program on a financially sound basis, which has been followed in the past, the committee bill would make provision for meeting the cost of the expanded program under the bill. To meet the cost of the improvements in the cash benefit programs and the extension of medicare coverage to disabled beneficiaries and to include drug coverage, the schedule of tax rates would be revised as shown in table 1 below. Under both present law and the committee bill, the limitation on wages taxable under social security would be increased from \$9,000 in 1972 to \$10,800 in 1973, to \$12,000 in 1974, and starting in 1975 the limit would rise as average wages increase.

TABLE 1.—SOCIAL SECURITY TAX RATES FOR EMPLOYERS,
EMPLOYEES, AND SELF-EMPLOYED PERSONS UNDER PRE-
SENT LAW AND COMMITTEE BILL

[In percent]

	Employer and employee, each			Self-employed		
	OASDI	HI	Total	OASDI	HI	Total
Present law:						
1972.....	4.6	0.6	5.2	6.9	0.6	7.5
1973.....	4.6	.9	5.5	6.9	.9	7.8
1974 to 1977.....	4.6	.9	5.5	6.9	.9	7.8
1978 to 1985.....	4.5	1.0	5.5	6.7	1.0	7.7
1986 to 1992.....	4.5	1.1	5.6	6.7	1.1	7.8
1993 to 2010.....	4.5	1.2	5.7	6.7	1.2	7.9
2011 and after.....	5.35	1.2	6.55	7.0	1.2	8.2
Committee bill:						
1972.....	4.6	.6	5.2	6.9	.6	7.5
1973 to 1977.....	4.9	1.1	6.0	7.0	1.1	8.1
1978 to 1980.....	4.95	1.3	6.25	7.0	1.3	8.3
1981 to 1992.....	4.95	1.5	6.45	7.0	1.5	8.5
1993 to 2010.....	4.95	1.6	6.55	7.0	1.6	8.6
2011 and after.....	6.05	1.6	7.65	7.0	1.6	8.6

TABLE 2.—SOCIAL SECURITY PROGRAMS: FIRST FULL-YEAR COST OF SENATE FINANCE COMMITTEE PROVISIONS OF H.R. 1

[Amounts in millions; numbers of persons in thousands]

Provision	Additional benefit payments in calendar year 1974	Present-law beneficiaries immediately affected ¹	Newly eligible persons
Total.....	\$6,371	(³)	(³)
Social security cash benefit programs:			
Increased benefits for widows and widowers up to 100 percent of PIA at age 65 (limited to OAIB).....	1,109	3,800	72
Retirement test changes ⁴ :			
\$2,400 exempt amount; \$1 for \$2 above \$2,400.....	1,078	1,190	550
Earnings in year of attainment of age 72.....	14	20	
Special minimum PIA up to \$200.....	152	700	
Credit for past and future delayed retirement.....	198	5,000	
Dependent sisters and disabled dependent brothers.....	79		50
Noncontributory credits for military service after 1956.....	46	130	
Eliminate support requirement for divorced wives and surviving divorced wives.....	23		10
Student child benefits payable after age 22 to end of semester ⁴ ..	19	55	6
Age 62 computation point for men.....	14		
Reduce disability waiting period to 4 months ⁴	274	950	8
Liberalized disability provisions for blind workers.....	246		250

Liberalized workmen's compensation offset (80 percent of high 1 year)	22	40	2
Children disabled at ages 18 to 21	17	.....	13
Increased allowance for vocational rehabilitation expenditures ⁵	29	.....	.....
Subtotal, cash benefit programs	3,320	(³)	889
Hospital insurance program:			
Coverage of the disabled	1,412	.....	1,696
Coverage of specific prescription drugs	740	21,071	1,696
Liberalize extended care benefits	110	20,592	1,696
Waiver of beneficiary liability for disallowed claims	85	20,592	1,696
Decrease coinsurance on lifetime reserve days	79	20,592	1,696
Subtotal, hospital insurance	2,426	(³)	.....
Supplementary medical insurance program:			
Coverage of the disabled	465	.....	1,696
Coverage of chiropractors services	113	20,684	1,696
Consolidation of outpatient rehabilitation care	16	20,512	1,696
Coverage of clinical psychologist services	7	20,512	1,696
Coverage of speech pathologist services	24	20,512	1,696
Subtotal, supplementary medical insurance	625	(³)	.....

¹ Except where noted, represents beneficiaries under present law whose benefit for the effective month would be increased.

² Except where noted, represents persons who cannot receive a benefit under present law for the effective month, but who would receive a benefit for such month under the provision.

³ Figures not additive because a person may be affected by more than one provision.

⁴ Number of present-law beneficiaries immediately affected represents persons who will receive additional benefits for months in

the first full year as a result of the provision. Number of newly eligible persons represents persons who will receive no benefits under present law for months in the first full year, but who would receive some benefits under the provision.

⁵ The allowance for fiscal year 1973 would be increased from 1 percent to 1½ percent of fiscal year 1972 benefit payments to disabled beneficiaries; the allowance for fiscal year 1974 and thereafter would be increased to 1½ percent of the previous fiscal year's benefit payments.

D. Supplemental Security Income for the Aged, Blind, and Disabled

PRESENT LAW

Three categories of adults are eligible for federally supported assistance: persons 65 and over, the blind (without regard to age), and permanently and totally disabled persons 18 years of age and older. Each State establishes a minimum standard of living (needs standard) upon which assistance payments are based; any aged, blind or disabled person whose income is below the State needs standard will be eligible for some assistance, although the State need not pay the full difference between the individual's income and the needs standard.

Generally speaking, all income and resources of an aged, blind or disabled person must be considered in determining the amount of the assistance payment (though a portion of earnings may be disregarded as a work incentive). States also place limitations on the real and personal property an aged, blind or disabled individual may retain without being disqualified for assistance.

Monthly State payments to an aged, blind or disabled individual with no other income range between \$75 and \$250 and for an aged couple between \$121 and \$350.

COMMITTEE BILL

The committee bill would replace the present State programs of aid to the aged, blind, and disabled with a new wholly Federal program of supplemental security income.

NATIONAL SUPPLEMENTAL SECURITY INCOME; DISREGARD OF SOCIAL SECURITY OR OTHER INCOME

Under the committee bill, aged, blind, and disabled persons with no other income would be guaranteed a monthly income of at least \$130 for an individual or \$195 for a couple. In addition the committee bill would provide that the first \$50 of social security or other income would not cause any reduction in supplemental security income payments.

As a result, aged, blind, and disabled persons who also have monthly income from social security or other sources (which are not need-related) of at least \$50 would, under the committee bill, be assured total monthly income of at least \$180 for an individual or \$245 for a couple.

At present, only twelve States have old age assistance programs which will guarantee a monthly income of at least \$180 for an individual receiving social security benefits (Alaska, California, Connecticut, Idaho, Illinois, Kansas, Massachusetts, Michigan, Nebraska, New York, South Dakota, and Washington). These States would, of course, be free to add to the Federal supplemental security income payments.

EARNED INCOME DISREGARD

In addition to providing for a monthly disregard of \$50 of social security or other income, the committee approved an additional disregard of \$85 of earned income plus one-half of any earnings above \$85. This will enable those aged, blind, and disabled individuals who are able to do some work to do so and in the process a higher income in addition to supplemental security income.

OTHER INCOME DISREGARDS

Under the supplementary security income program also, any rebate of State or local taxes (such as real property or food taxes) received by an aged, blind or disabled person would not be counted as income.

DEFINITIONS OF BLINDNESS AND DISABILITY

Under present law each State is free to prescribe its own definition of blindness and disability for purposes of eligibility for aid to the blind and aid to the permanently and totally disabled.

Under the new supplemental security income program, there would be a uniform Federal definition of "disability" and "blindness."

The term "disability" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Under the disability insurance program, this definition is now found in section 223(d)(1) of the Social Security Act. The provisions of the disability insurance program further specify that this definition is met only if the disability is so severe that an individual "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." (Sec. 223(d)(2)(A).)

The term "blindness" would be defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. (Sec. 216(i)(1)(B).) Also included in this definition is the particular sight limitation which is referred to as "tunnel vision."

STATE SUPPLEMENTATION

States wishing to pay an aged, blind or disabled person amounts in addition to the Federal supplemental security income payment would be free to do so. The Committee bill would permit States to enter into agreements for Federal administration of State supplemental benefits. Under these agreements, supplemental payments would have to be made to all persons eligible for Federal supplemental security income payments under the Committee bill except

that a State could require a period of residence in the State as a condition of eligibility.

OTHER FEDERAL ELIGIBILITY STANDARDS

Eligibility for supplemental security income would be open to an aged, blind or disabled individual if his resources were less than \$2,500. In determining the amount of his resources, the value of the home, household goods, personal effects, including an automobile, and property needed for self support would, if found to be reasonable, be excluded. Also, life insurance policies would not be counted if the face value of all policies was less than \$1,500.

MEDICAID COVERAGE

Under present law, the States are required to cover all cash assistance recipients under the medicaid program. The committee bill, like the House version, would exempt from this requirement newly eligible recipients who qualify because of the previously agreed provision of a \$130 minimum benefit with a disregard of \$50 of social security and other income.

SOCIAL SERVICES

Under the committee bill, States would be authorized to continue programs providing social services to aged, blind, and disabled persons. These services are currently provided under the welfare programs for the aged, blind, and disabled which would be replaced by the new Federal supplemental security income program. There would be 75 percent Federal matching for the services provided, subject to overall limitations described in the section of the report dealing with aid to families with dependent children.

TABLE 3.—OLD-AGE ASSISTANCE: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972

	Aged individual		Aged couple	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
Alabama.....	\$158	\$115	\$266	\$230
Alaska.....	250	250	350	350
Arizona.....	118	118	164	164
Arkansas.....	149	105	210	210
California.....	183	183	330	330
Colorado.....	145	145	290	290
Connecticut.....	238	238	286	286
Delaware.....	140	140	197	197
District of Columbia.....	113	113	158	158
Florida.....	121	121	160	160
Georgia.....	102	96	159	159
Hawaii.....	132	132	205	205
Idaho.....	182	182	219	219
Illinois.....	173	173	214	214
Indiana.....	185	80	247	160
Iowa.....	117	117	178	178
Kansas.....	203	203	247	247
Kentucky.....	96	96	160	160
Louisiana.....	147	100	235	188
Maine.....	123	115	214	214
Maryland.....	96	96	131	131
Massachusetts.....	189	189	280	280
Michigan.....	184	184	237	237
Minnesota.....	158	158	230	230
Mississippi.....	150	75	218	150
Missouri.....	181	85	247	170
Montana.....	111	111	175	175
Nebraska.....	182	182	235	235
Nevada.....	170	170	271	271
New Hampshire.....	173	173	228	228
New Jersey.....	162	162	222	222
New Mexico.....	116	116	155	155
New York.....	184	184	234	234
North Carolina.....	115	115	153	153

TABLE 3.—OLD-AGE ASSISTANCE: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972—Continued

	Aged individual		Aged couple	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
North Dakota.....	\$125	\$125	\$190	\$190
Ohio.....	126	126	212	212
Oklahoma.....	130	130	212	212
Oregon.....	122	122	177	177
Pennsylvania.....	138	138	208	208
Rhode Island.....	163	163	211	211
South Carolina.....	87	87	121	121
South Dakota.....	180	180	220	220
Tennessee.....	102	97	194	142
Texas.....	119	119	192	192
Utah.....	112	112	150	150
Vermont.....	177	177	233	233
Virginia.....	152	152	199	199
Washington.....	149	149	214	214
West Virginia.....	123	123	156	156
Wisconsin.....	175	175	241	241
Wyoming.....	139	104	195	178

TABLE 4.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972

	Blind individual		Disabled individual	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
Alabama.....	\$125	\$125	\$71	\$71
Alaska.....	250	250	250	250
Arizona.....	118	118	118	118
Arkansas.....	149	105	149	105
California.....	198	198	177	177
Colorado.....	105	105	123	123
Connecticut.....	238	238	238	238
Delaware.....	189	150	117	117
District of Columbia.....	113	113	113	113
Florida.....	121	121	121	121
Georgia.....	102	96	100	96
Hawaii.....	132	132	132	132
Idaho.....	182	182	182	182
Illinois.....	173	173	173	173
Indiana.....	185	125	185	80
Iowa.....	144	144	117	117
Kansas.....	203	203	203	203
Kentucky.....	96	96	96	96
Louisiana.....	106	101	99	66
Maine.....	123	115	123	115
Maryland.....	96	96	96	96
Massachusetts.....	180	180	178	178
Michigan.....	184	184	184	184
Minnesota.....	158	158	158	158
Mississippi.....	150	75	150	75
Missouri.....	255	100	170	80
Montana.....	123	123	111	111
Nebraska.....	182	182	182	182
Nevada.....	155	155	(1)	(1)
New Hampshire.....	173	173	173	173
New Jersey.....	162	162	162	162
New Mexico.....	116	116	116	116
New York.....	184	184	184	184
North Carolina.....	120	120	115	115
North Dakota.....	125	125	125	125

TABLE 4.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972—Continued

	Blind individual		Disabled individual	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
Ohio.....	\$126	\$126	\$116	\$116
Oklahoma.....	130	130	130	130
Oregon.....	163	163	122	122
Pennsylvania.....	150	150	138	138
Rhode Island.....	163	163	163	163
South Carolina.....	103	95	87	80
South Dakota.....	180	180	180	180
Tennessee.....	102	97	102	97
Texas.....	110	110	110	105
Utah.....	122	122	112	122
Vermont.....	177	177	177	177
Virginia.....	153	153	152	152
Washington.....	149	149	149	149
West Virginia.....	123	123	123	123
Wisconsin.....	175	175	175	175
Wyoming.....	139	104	127	104

¹ No program.

E. Guaranteed Job Opportunity for Families

The whole Nation has become increasingly concerned at the rapid growth of the welfare rolls in recent years, and with good reason.

By far the major factor in this growth has been the increase in the number of persons receiving Aid to Families with Dependent Children. From 5.3 million recipients at the end of 1967, the number of AFDC recipients doubled during the next four years. The soaring costs of this program have forced States to shift funds into welfare that would otherwise go for education, health, housing and other pressing social needs. There is universal agreement that something must be done, but there remains much confusion about the nature of the problem that must be solved. The committee feels that a more expensive and expansive welfare program is *not* the answer.

The soaring welfare rolls reflect three developments.

First, they show that there are a large number of children in this country who are needy and whose parents in most cases are not working.

Second, they show an alarming increase in dependency on the taxpayer. The proportion of children in this country who are receiving AFDC has climbed sharply, from three percent in the mid-fifties to nine percent today. This means that an increasing number of families are becoming dependent on welfare and staying dependent on welfare.

Third, the growth in the AFDC rolls reflects increasing family breakup and increasing failure to form families in the first place. Births out of wedlock, particularly to teenage mothers, have increased sharply in the past decade. Two striking statistics highlight the problem: the number of families headed by women increased by 15 percent between 1970 and 1971, while the number of families with both father and mother present declined in absolute numbers during the same one-year period. Today, almost 8 million women and children receive welfare because of the "absence of the father from the home"—principally due to family breakup or failure of the father to marry the mother of his child.

Many persons who strongly advocate increasing welfare benefits have simply glossed over the problems of family breakup and the increase of births out of wedlock. Even more importantly, they have avoided discussing the problem of increasing dependency.

In an article that appeared in the *New York Magazine* in October, 1971, Nathan Glazer raises the fundamental question of what increasing dependency on welfare has done for recipients in New York City:

Has it reduced starvation and given them more food? Has it improved their housing? Has it improved their environment? Has it improved their clothing? Has it heightened their self-respect and sense of power? Has it better and more effectively incorporated them into the economic and political life of the city? . . . Blanche Bernstein, director of research at the New School's Center for New York City Affairs, has estimated that 50 percent of

the increase in welfare recipients in New York City during the 1960's was due to desertion and 25 percent was due to illegitimate births. She reports that in 1961 there were 12,000 deserted families on welfare in New York City. By 1968 there were 80,000. What happened in New York City was not an explosion in welfare alone. The city witnessed an explosion in desertion and in illegitimacy. . . .

Welfare, along with those who pressed its expansion, deprived the poor of New York of what was for them—as for the poor who preceded them—the best and indeed only way to the improvement of their condition, the way that involved commitment to work and the strengthening of family ties. In place of this, the advocates of revolution through welfare explosion propagated a false and demeaning sense of the “rights” of the poor, one which had disastrous consequences

Relief is necessary to the poor. In any civilized society it must be given generously, and if needed, extensively. But it should be the aim of every society to find and encourage other means to the maintenance of a decent standard of living than the distribution of charity. For whatever the position of modern advocates of welfare rights, welfare can never, if given regularly on an extensive scale, be other than alms, and whatever alms did for the souls of those who gave them, they could not be good for the souls of those who received them. Every society—capitalist, socialist, or “welfare state”—tries to find ways to replace money relief and to make it unnecessary. To advocate its expansion as a means of dealing with distress is one thing; to advocate its expansion as a means of breaking the commitment to work with its attendant effects on self-respect and on family life is irresponsible.

The fundamental problem is raised somewhat differently in an article entitled “Welfare: the Best of Intentions, the Worst of Results” that appeared in the August, 1971, issue of *Atlantic Magazine*. The author, Irving Kristol, begins by quoting from the 19th century social commentator Alexis de Tocqueville:

There are two incentives to work: the need to live and the desire to improve the conditions of life. Experience has proven that the majority of men can be sufficiently motivated to work only by the first of these incentives. The second is only effective with a small minority. . . . A law which gives all the poor a right to public aid, whatever the origin of their poverty, weakens or destroys the first stimulant and leaves only the second intact.

At this point, we are bound to draw up short and take our leave of Tocqueville. Such gloomy conclusions, derived from a less than benign view of human nature, do not recommend themselves either to the twentieth-century political imagination or to the American political temperament. We do not like to think that our instincts of social compassion might have dismal consequences—not accidentally but inexorably. We simply cannot believe that the universe is so constituted. We much prefer, if a choice has to be made, to have a good opinion of mankind and a poor opinion of our socio-economic system. . . .

Somehow, the fact that more poor people are on welfare, receiving more generous payments, does not seem to have made this

country a nicer place to live—not even for the poor on welfare, whose condition seems not noticeably better than when they were poor and off welfare. Something appears to have gone wrong: a liberal and compassionate social policy has bred all sorts of unanticipated and perverse consequences. . . .

To raise such questions is to point to the fundamental problems of our welfare system, a vicious circle in which the best of intentions merge into the worst of results.

As Congress examines fundamental questions concerning the effect of dependency on welfare, it must also take note of developments in American society, such as the changing role of women in America and the increasing public demand for action to improve the quality of life in this country.

When the AFDC program was first established under the Social Security Act of 1935, American society generally viewed a mother's role as requiring her to stay at home to take care of her children; she would be considered derelict in her duties if she failed to do so. But values have changed, and today, one-third of all mothers with children under age six are members of the labor force, and *more than half* of the mothers with school-age children only are members of the labor force. Furthermore, in families where the father is not present, two-thirds of the mothers with children over age six are in the labor force. This number has been growing steadily in the past 20 years, and it may be expected to continue to grow.

At the same time, it is widely recognized today that many important tasks in our society remain undone, such as jobs necessary to improve our environment, improve the quality of life in our cities, improve the quality of education in our schools, improve the delivery of health services, and increase public safety in urban areas. The heads of welfare families are qualified to perform many of these tasks. Yet welfare pays persons not to work and penalizes them if they do work. Does it make sense to pay millions of persons not to work at a time when so many vital jobs go undone? Can this Nation continue to consider unemployable mothers of school-age children on welfare and pay them to remain unemployed when more than half of mothers with school-age children in the general population are already working?

It is the committee's conclusion that paying an employable person a benefit based on need, the essence of the welfare approach, has not worked. It has not decreased dependency—it has increased it. It has not encouraged work—it has discouraged it. It has not added to the dignity in the lives of recipients, and it has aroused the indignation of the taxpayers who must pay for it.

As President Nixon has stated:

In the final analysis, we cannot talk our way out of poverty; we cannot legislate our way out of poverty; but this Nation can work its way out of poverty. What America needs now is not more welfare, but more "workfare". . . . This would be the effect of the transformation of welfare into "workfare," a new work-rewarding program.

The committee agrees that the only way to meet the economic needs of poor persons while at the same time decreasing rather than increasing their dependency is to reward work directly by increasing its value. The committee bill seeks to put the President's words into practice by:

(1) Guaranteeing employable family heads a job opportunity rather than a welfare income; and by

(2) Increasing the value of work by relating benefits directly to work effort.

In meeting these objectives the committee bill will substantially increase Federal expenditures to low-income working persons, but the increased funds that go to them—about \$2.4 billion—will be paid in the form of wages and wage supplements, not in the form of welfare, since the payments will be related to work effort rather than to need. Under the welfare system, an employed person who cuts his or her working hours in half receives a much higher welfare payment; under the committee bill, a person reducing his or her work effort by half would find the Federal benefits also reduced by half.

DESCRIPTION OF PROGRAM

Under the guaranteed employment program recommended in the committee bill, persons considered employable would not be eligible to receive their basic income from Aid to Families with Dependent Children but would be eligible on a voluntary basis to participate in a wholly federally financed employment program. Thus, employable family heads would not be eligible for a guaranteed welfare income, but would be guaranteed an opportunity to work.

In the description of the guaranteed job program that follows, it is assumed that the Federal minimum wage will rise to at least \$2.00 per hour.

The following table shows which families would continue to be eligible for welfare and those which would no longer be eligible to receive their basic income from welfare under the committee bill:

<i>Eligible for Welfare</i>	<i>Not Eligible To Receive Basic Income from Welfare</i> ¹
1. Family headed by mother with child under age 6	1. Family headed by able-bodied father
2. Family headed by incapacitated father where mother is not in the home or is caring for father	2. Family headed by mother with no child under 6 (unless the mother is attending school full time)
3. Family headed by mother who is ill, incapacitated, or of advanced age	
4. Family headed by mother too remote from an employment program to be able to participate	
5. Family headed by mother attending school full time even if there is no child under 6	
6. Child living with neither parent, together with his caretaker relative(s) (though State may deny welfare if his mother is also receiving welfare)	

¹ These families would be eligible for State supplementation if the State payment level is over \$2,400 a year for the family and if otherwise eligible under the State requirements.

An estimated 40 percent or 1.2 million of the 3 million families currently receiving Aid to Families with Dependent Children would have to obtain their basic source of income from employment once the committee bill becomes effective.

All heads of families, whether eligible for welfare or not, as well as heads of families no longer eligible for welfare, could volunteer to participate in the new employment program.

The committee bill provides three basic types of benefit to heads of families:

1. A guaranteed job opportunity with a newly established Work Administration paying \$1.50 per hour for 32 hours and with maximum weekly earnings of \$48.

2. A wage supplement for persons employed at less than \$2.00 per hour (but at least at \$1.50 per hour) equal to three quarters of the difference between the actual wage paid and \$2.00 per hour.

3. A work bonus equal to 10 percent of wages covered under social security up to a maximum bonus of \$400 with reductions in the bonus as the husband's and wife's income rises above \$4,000.

WORK INCENTIVES UNDER THE PROGRAM

The program would guarantee each family head an opportunity to earn \$2,400 a year, the same amount as the basic guarantee under the House bill for a family of four. It also strengthens work incentives rather than undermine them, as shown in the table below.

In table 5, the three types of employment are compared under the guaranteed employment program.

The table also shows what happens to total family income under the proposal if the father works 40 hours a week (32 hours in the case of Government employment), 20 hours a week, or no hours a week.

The sources of income shown are: (a) wages paid by the employer, (b) wages paid by the Government, either as employer or in the form of a wage supplement to the employee (for those in jobs paying less than \$2.00 per hour), and (c) the work bonus equal to 10 percent of wages covered under social security.

The table shows these major points about the committee plan:

- (1) Since the participant is paid for working, his wages do not vary with family size. Thus a family with one child would have no economic incentive to have another child. This feature also preserves the principle of equal pay for equal work.

- (2) As the employee's rate of pay increases, his total income increases.

- (3) As the employee's income rises due to higher pay in a regular job, the cost to the Government decreases. \$1.50-per-hour employment by the Government costs the taxpayer \$48 for a 32-hour week; working 40 hours for a private employer at the same \$1.50 hourly rate gives the employee a \$33 boost in income while cutting the cost to the Government by \$27. Moving to an unsubsidized job at \$2.00 per hour increases the employee's income another \$7 while saving the Government about \$13 more.

- (4) The less the employee works, the less he gets. No matter what the type of employment, the employee who works half-time

gets half of what he would get if he works full time; he gets no Federal benefit if he fails to work at all.

(5) The value of working is increased rather than decreased. Working 32 hours for the Government is worth \$1.50 per hour; when a private employer pays \$1.50, the value of working to the employee is \$2.02 per hour; and working at \$2.00 per hour is worth \$2.20 per hour to the employee. This will assure that any participant in private employment will receive more than \$2.00 an hour. Under the House bill, by way of contrast, the value of working is decreased rather than increased, since the family would be eligible for welfare benefits if the family head does nothing.

Wage paid by employer	Actual value of 40 hours of employment under—	
	House Bill (cents)	Committee bill
\$1.50	73	\$2.02
\$2.00	¹ 90	2.20

¹\$1.23 for a family of 2; \$1.04 for a family of 3.

(6) Earnings from other employment do not decrease the wages received for hours worked. Thus an individual able to work in private employment part of the time increases his income and saves the Government money. Virtually no policing mechanism is necessary to check up on his income from work.

TABLE 5.—WORK INCENTIVES UNDER THE COMMITTEE BILL

	Employed by—		
	Government at \$1.50 per hour	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
<i>40 hours worked (32 hours if Government employment):</i>			
Wages paid by—			
Employer.....		\$60.00	\$80.00
Government.....	\$48.00	15.00	.....
Special 10-percent payment.....		6.00	8.00
Total Government payment... ..	48.00	21.00	8.00
Total income.....	48.00	81.00	88.00
<i>20 hours worked: (16 hours if Government employment):</i>			
Wages paid by—			
Employer.....		30.00	40.00
Government.....	24.00	7.50	.....
Special 10-percent payment.....		3.00	4.00
Total Government payment... ..	24.00	10.50	4.00
Total income.....	24.00	40.50	44.00
No hours worked.....	0	0	0
Hourly value of working.....	1.50	2.02	2.20

WORK DISINCENTIVES UNDER PRESENT LAW AND HOUSE BILL

By way of contrast, under present law a mother who is eligible for welfare is guaranteed a certain monthly income (at a level set by the State) if she has no other source of income; if she begins to work, her welfare payment is reduced. Specifically, in addition to an allowance for work expenses, her welfare payment is reduced \$2 for each \$3 earned in excess of \$30 a month. Generally, then, for each dollar earned and reported to the welfare agency, the family's income is increased by 33 cents.

The House bill uses the same basic approach as present law but substitutes a flat \$60 exemption plus one-third of additional earnings for the present \$30 plus work expenses plus one-third of additional earnings. The disincentive effects of this are clearly illustrated in the following examples of the effect of the House bill on the head of a family of 4 as shown in table 6:

(1) The less the individual works, the more the Government pays. For example, an individual working at \$2.00 per hour for 20 hours receives \$26.60 more in welfare than an individual working 40 hours a week at that wage; if he does not work at all, his government benefit goes up by \$44.10.

(2) An individual cutting back on his work effort decreases his income by a relatively smaller amount, or, said another way, the value of work is substantially lower under the House bill than under the committee bill. The total income of an individual working at \$2.00 per hour for 20 hours under the House bill is only about \$13 less than his total income if he works full time at that wage. An individual who works not at all receives only \$36 less than the \$82 received by an individual working 40 hours at \$2.00 an hour.

(3) The value of working is decreased rather than increased. Since the family is eligible for \$46.20 in welfare for doing nothing, the \$29.20 in additional family income for 40 hours of work at \$1.50 per hour amounts to a value of only 73¢ an hour for working. Working 40 hours a week at \$2.00 per hour is worth only 90¢ per hour to the employee.

(4) Earnings from any employment (as well as child support payments), if reported, reduce the benefits received by the family.

TABLE 6.—WORK DISINCENTIVES UNDER THE HOUSE BILL:
INCOME FOR FAMILY OF 4

	Employed by—	
	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
40 hours worked:		
Wages.....	\$60.00	\$80.00
Welfare.....	15.40	2.10
Total income.....	75.40	82.10
20 hours worked:		
Wages.....	30.00	40.00
Welfare.....	35.40	28.70
Total income.....	65.40	68.70
No hours worked:		
Wages.....	0	0
Welfare.....	46.20	46.20
Total income.....	46.20	46.20
Hourly value of working 40 hours.....	.73	.90

ELIGIBILITY TO PARTICIPATE

Except as noted below, eligibility to participate in the employment program would be open to all family heads who are U.S. citizens or aliens lawfully admitted for permanent residence with a child under age 18 (or under age 21 and attending school full time). Participation would be purely voluntary. Mothers with children under age 6 who were eligible for welfare would also be eligible to participate in the employment program if they so chose.

PARTICIPATION IN WORK PROGRAM

Only one member of a family would be eligible to participate in the work program, the head of the household. This would be deemed to be the father unless he was dead, absent, or incapacitated, in which case it would be deemed to be the mother.

A head of a household would not be permitted to participate in the employment program as a \$1.50-per-hour Government employee if he or she:

- (1) is a substantially full time student;
- (2) is a a striker, but this disqualification would *not* apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off work because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the government financing one side of a labor-management dispute.
- (3) is receiving unemployment compensation;
- (4) is a single person or is a member of a couple with no child under 18 (or under age 21 and attending school full time); or
- (5) has left employment without good cause or been discharged for cause or misconduct during the prior 60 days. The Work Administration would be authorized to extend the disqualification to as much as six months for individuals who are discharged because of malicious misconduct or for the commission of a crime against their employer.

In addition:

- (6) a family would be ineligible if it has unearned income in excess of \$250 monthly or if total family income exceeds \$5,600 annually; and
- (7) if an individual is able to find regular employment on a part-time basis, he or she will be assured an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours work per week. If an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, an individual working full time for the Government under the

employment program could work an additional 20 hours with no reduction in the number of hours of Government employment he or she is provided.

KINDS OF EMPLOYMENT

Three kinds of employment are provided :

1. Regular employment in the private sector or in jobs in public or nonprofit private agencies ;
2. Private or public employment with the employee's wages supplemented ; and
3. Newly developed jobs, with the Federal Government bearing the full cost of the salary.

PLACEMENT IN REGULAR EMPLOYMENT

Some participants with little or no preparation could be placed immediately in regular employment involving no Government subsidy. These jobs would all pay at least \$2.00 per hour.

PUBLIC OR PRIVATE EMPLOYMENT WITH WAGE SUPPLEMENTS

In this category would be jobs not covered by the Federal minimum wage law, in which the employer paid less than \$2.00 per hour but at least \$1.50 per hour. No supplement would be paid if the employer reduced pay for the job because of the supplement. Thus no jobs presently paying the minimum wage would be downgraded under the committee bill, and the minimum wage itself would not be affected. Rather, the supplement relates solely to those jobs not covered today under the minimum wage law. Some of these include :

Small retail stores :	Outside salesmen in any industry.
Sales clerk	
Cashier	Public sector :
Cleanup man	Recreation aide
	Swimming pool attendant
Small service establishments :	Park service worker
Beautician assistant	Environmental control aide
Waiter	Ecology aide
Waitress	Sanitation aide
Busboy	Library assistant
Cashier	Police aide
Cook	Fire department assistant
Porter	Social welfare service aide
Chambermaid	Family planning aide
Counter man	Child care assistant
	Consumer protection aide
Domestic service :	Caretaker
Gardener	Home for the aged employee
Handyman	
Cook	Agricultural labor :
Household aide	Jobs picking, grading, sorting, and grading crops ;
Child attendant	spraying, fertilizing, and other preparatory work ;
Attendant for aged or disabled person	milking cows ; caring for livestock

For these jobs, the Federal Government would make a payment to any employee who is the head of a household equal to three quarters of the difference between what the employer pays him and \$2.00 per hour, for up to 40 hours a week. Thus if an employer paid \$1.50 an hour the Federal supplement would amount to 38 cents an hour (three-quarters of the 50-cent difference between \$1.50 and \$2.00). This wage supplement would be administered by the local office of the Work Administration.

GUARANTEED EMPLOYMENT

For persons who could not be placed in public or private employment (with or without a wage supplement), jobs would be created which would pay at the rate of \$1.50 per hour. An individual could work up to 32 hours a week (an annual rate of about \$2,400), and would be paid on the basis of hours worked just as in any other job. There would be no pay for hours not worked.

However, a woman with school-age children would not be required to be away from home during hours that the children are not in school (unless child care is provided), although she may be asked, in order to earn her wage, to provide after-school care to children other than her own during these hours.

Participants would not be considered Federal employees, nor would they be covered by social security, unemployment compensation or workmen's compensation. The 10 percent special work-bonus would not apply to their salary.

For these individuals who cannot be placed immediately in regular employment at a rate of pay at least equal to the minimum wage, or in employment with a wage supplement, the major emphasis would be on having them perform useful work which can contribute to the betterment of the community. A large number of such activities are currently going undone because of the lack of individuals or funds to do them. With a large body of participants for whom useful work will have to be arranged, many of these community improvement activities could now be done. At the same time, safeguards are provided so that the program meets the goal of opening up new job opportunities and does not simply replace existing employees, whether in the public or private sector.

Any job in the regular economy paying \$1.50 per hour or more, even a part-time job, would yield a greater income than \$1.50 per-hour Government employment and it is anticipated that this will serve as an incentive for participants to seek regular employment. In addition, the cost to the Government would be substantially less for an individual in regular employment.

WORK BONUS FOR LOW-INCOME WORKERS

Low-income workers in regular employment who head families would be eligible for a work bonus equal to 10 percent of their wages taxed under the social security (or railroad retirement) program, if the total income of the husband and wife is \$4,000 or less. For families where the husband's and wife's total income exceeds \$4,000, the work bonus would be equal to \$400 minus one-quarter of the amount by which this income exceeds \$4,000. Thus there would be no work bonus once total income reached \$5,600 (\$5,600 exceeds \$4,000 by

\$1,600; one-quarter of \$1,600 is \$400, which subtracted from \$400 equals zero).

The size of the work bonus is shown on the table below for selected examples:

Annual income of husband and wife (assuming it is all taxed under social security)	Work bonus
\$2,000.....	\$200
3,000.....	300
4,000.....	400
5,000.....	150
5,600.....	0

The plan incorporates the features of (1) not varying benefits by family size, but only by income, providing no economic incentive for having additional children; and (2) having a gradual phaseout of the amount of the payment as income rises above \$4,000 so as not to create a work disincentive.

There are certain types of work which are covered under social security but only when the amount of wages earned from a single employer exceeds \$50 in a quarter. This limitation applies to the employment of domestics, yardmen and other similar non-business employees. Such employees, if they are the heads of a family, would get the work bonus with respect to all of their wages including those not covered by social security because of the \$50 quarterly limitation. In order to qualify for the work bonus on these wages, however, the individual would have to arrange to perform the work as an employee of the Work Administration which would pay him the prevailing wage for the job and bill the private employer for the wages and other costs associated with making his services available. If the employment would ordinarily be covered by social security, then it will be covered under social security when arranged on this basis by the Work Administration. If the employment is not covered by social security, then the employer will not have to pay social security taxes. In either case, the Work Administration will have a record of all such wages which would have been subject to social security taxes on which the payment of the work bonus may be based.

The 10 percent work bonus would be administered by the Internal Revenue Service.

TRANSPORTATION ASSISTANCE

In recognition of the fact that a major reason for low-skilled jobs going unfilled in metropolitan areas is the difficulty an individual faces getting to the potential job, the Work Administration would be authorized to arrange for transportation assistance where this is necessary to place its employees in regular jobs. For example, the Work Administration might determine the upper limit of transportation time to get to a job—say, 45 minutes or one hour, depending on the average commuting time in the area. If the individual can get to the job within that amount of time through ordinary public transportation or other arrangements, then he would be expected to do so. If this could not be done, however, then the Work Administration would be authorized to provide transportation directly to employees who

could be placed in regular jobs in order to cut the transportation time down to the standard. The Work Administration could only do this where it was necessary in order to increase employment opportunities. In any case, the cost would ordinarily not be borne by the Government—the employee would pay the Work Administration, and perhaps be reimbursed by the employer if this is customary in the area for the type of job involved. The Work Administration would have the flexibility to absorb some of the costs involved in unusual circumstances.

INSTITUTIONAL TRAINING

Participants in the employment program would be eligible to volunteer for training to improve their skills under the training program administered by the Work Administration. The individual would be accepted for enrollment to the extent funds are available and only if the individual is determined to be:

1. Capable of completing training; and
2. Able to become independent through employment at the end of the training and as a result of the training.

Employees under the employment program who wished to participate in training would be strongly motivated, for they would be paid only \$1.25 rather than \$1.50 for each hour of training. Following the successful completion of training (which could not exceed 1 year in duration), the trainee would receive a lump-sum bonus for having completed training equal to 10 percent of the total training stipends which he received while he was in training.

SERVICES

Since the purpose of the proposal is to improve the quality of life for children and their families, any member of a family whose head participates in the work program could be provided services to strengthen family life or reduce dependency, to the extent funds are available to pay for the services. Open-ended funding would be provided for family planning and child care services (the latter for families with no preschool-age children). The agency administering the employment program would refer family members to other agencies in arranging for the provision of social and other services which they do not provide directly. For example, a disabled family member might be referred to the vocational rehabilitation agency, or a 16-year-old out-of-school youth might be referred to an appropriate work or training program, even though the cost of the services themselves would not be borne by the employment program.

Former participants in the work program would have access to free family planning services and to child care on a wholly or partly subsidized basis, depending on family income. Other services needed to continue in employment, including minor medical needs, could be provided by the agency administering the program.

STATE SUPPLEMENTATION

In order to prevent the State welfare program from undermining the objectives of the Federal employment program the State would

have to assume that individuals eligible for the State supplement who are also eligible to participate in the employment program are actually participating full time and thus receiving \$200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Furthermore, the State would be required to disregard any earnings between \$200 a month and \$375 a month (the amount an employee would earn working 40 hours a week at \$2.00 per hour) to ensure that the incentive system of the alternative plan is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of \$200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at \$1.50 per hour.

FOOD STAMPS

Individuals participating in the employment program would not be eligible to participate in the food stamp program. However, States would be reimbursed the full cost of adjusting any supplementary benefits they might decide to give to participants so as to make up for the loss of food stamp eligibility. In order to avoid having States provide assistance to an entirely new category of recipient not now eligible for federally-shared Aid to Families with Dependent Children, the committee provided that the Work Administration would pay families headed by an able-bodied father the amount equal to the value of food stamps (but only to the extent that the State provides cash instead of food stamps for families which are now in the Aid to Families with Dependent Children category).

CHILDREN OF MOTHERS REFUSING TO PARTICIPATE IN THE EMPLOYMENT PROGRAM

Under the employment program, mothers in families with no children under age six would generally be ineligible to receive their basic income from the Aid to Families with Dependent Children program. It is possible that a few mothers will ignore the welfare of their children and refuse to take advantage of the employment opportunity. To prevent the children from suffering because of such neglect, the Work Administration would be authorized to make payment to the family for up to one month if the mother is provided counseling and other services aimed at persuading her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to vocational rehabilitation agency; or, if she is not found to be incapacitated, the State could arrange for protective payments to a third party to ensure that the needs of the children are provided for.

ADMINISTRATION OF THE EMPLOYMENT PROGRAM

The employment program would be administered by a newly created Work Administration headed by a 3-man board appointed by the Pres-

ident with the advice and consent of the Senate. The actual operations of the program would be carried out by local offices of the Work Administration.

The local office would hire individuals (mostly participants or former participants), develop employability plans for participants, attempt to expand job opportunities in the community, arrange for supportive services needed for persons to participate (utilizing the Work Administration's Bureau of Child Care to arrange for child care services), and operate programs utilizing participants which are designed to improve the quality of life for the children of participants in the employment program.

EMPLOYMENT PROGRAM IN PUERTO RICO

Certain modifications relating to the employment program in Puerto Rico were made. These modifications are necessary because of the fact that Puerto Rico has a different minimum wage structure than the rest of the United States, has substantially lower per capita income, and has a high rate of unemployment. Under the committee bill the wages paid to Government employees would be equal to three-quarters of the lowest minimum wage applicable to a significant percentage of the population. This would result in a lower wage for Government employees than in the rest of the United States, but it would be significantly higher than current welfare payments in Puerto Rico. The wage supplement program for persons in regular employment at less than the minimum wage would not be applicable to Puerto Rico, but the 10 percent work bonus for low-income earners in jobs covered by social security would apply.

TAX CREDIT TO DEVELOP JOBS IN THE PRIVATE SECTOR

The provision of the present tax law under which an employer hiring a participant in the Work Incentive Program is eligible for a tax credit equal to 20 percent of the employee's wages during the first 12 months of employment, with a recapture of the credit if the employer does not retain the employee for at least one additional year (unless the employee voluntarily leaves or is terminated for good cause), will be continued under the new guaranteed employment program.

Because the guaranteed job opportunity program, unlike the Work Incentive Program, would be open to the head of any family with children, the following limitations would be added to the provisions of the tax credit to ensure that the credit meets the primary aim of expanding employment opportunities for participants in the committee's work program:

1. The credit would apply only with respect to individuals who have been participating in the guaranteed job program for at least one month;
2. The credit would not be applicable with respect to more than 15 percent of all employees of the employer in any one year (though the employer would always be permitted to take the credit for at least one employee);

3. The credit would not be available with respect to an employee who replaces an employee who was discharged without good cause; and

4. The credit could not exceed \$800 in the case of any one employee (20 percent of \$4,000, approximately the amount of annual earnings at \$2 an hour).

In order to create additional employment opportunities for participants in the guaranteed job program, the committee bill would extend the credit to private employers hiring participants in addition to businesses. A private employer taking the credit would not be eligible at the same time for the income tax child care or household expense deduction.

EFFECTIVE DATES

The effective date for the basic job opportunity program is January 1974. As of that date, families which include an employable adult (including a mother with no child under age 6) will no longer be eligible for welfare as their basic income. If unable to find a regular job, however, the family head will be assured of Government employment paying \$1.50 an hour for 32 hours weekly, producing \$2,400 of income annually, the same amount which would have been payable to a family of 4 under the House-passed family assistance plan.

The 10 percent work bonus and the wage supplement payment would become payable even before the full guaranteed employment program is operative. Specifically, the work bonus which will be paid quarterly to low-income workers will become effective starting in January 1973. The wage supplement for family heads in regular jobs not covered under the minimum wage law and paying less than \$2.00 per hour will be effective July 1973, utilizing the services of the local employment service offices to make the payments until the Work Administration mechanism is functioning.

F. General Provisions, Child Welfare Services, and Other Provisions

1. GENERAL PROVISIONS

QUALITY OF WORK PERFORMED BY WELFARE PERSONNEL

In an effort to try to upgrade the quality of work performed by welfare personnel, the committee bill directs the Secretary of the Department of Health, Education, and Welfare to study and report to the Congress by January 1, 1974, on ways of enhancing the quality of welfare work, whether by fixing standards of performance or otherwise. In making this study, the Secretary could draw on the knowledge and expertise of persons talented in the field of welfare administration, including those having direct contact with recipients. He should also benefit from suggestions made by recipients themselves as to how the level of performance in the administration of the welfare system might be improved, with a view toward ending the wide variations in employee conduct which characterize today's system, and moderating the extremes to which some social workers go in performing their duties.

OFFENSES BY WELFARE EMPLOYEES

Under present Federal law there is no provision particularly directed to the question of employee conduct in the administration of the welfare program. On the other hand, the Internal Revenue Code (Sec. 7214) contains a list of offenses the commission of any of which, by a tax employee, would bring into effect discharge from employment and penalties of (a) fines not to exceed \$10,000, or (b) imprisonment for not more than five years, or both. The provision in the Internal Revenue Code also authorizes a court to award out of any fines imposed an amount up to one-half of the fine to be paid to the informer whose information resulted in the detection of the criminal offense. This law has contributed to the high quality of performance of Internal Revenue employees and has been a factor in assuring relatively uniform standards of conduct.

Under the committee bill similar rules would apply under the welfare laws that could relate to an upgrading of the quality of performance by welfare workers in general and serve as the basis for standards of conduct which hopefully might narrow the wide variations in employee conduct which exist today.

Specifically, under the committee bill it would be a crime punishable by a fine of up to \$10,000 or imprisonment of up to 5 years, or both, in the case of a welfare employee who is found guilty of:

- (1) extortion or willful oppression under color of law; or
- (2) knowingly allowing the disbursement of greater sums than

are authorized by law, or receiving any fee, compensation, or reward, except as prescribed, for the performance of any duty; or

(3) failing to perform any of the duties of his office or employment with intent to defeat the application of any provision of the welfare statute; or

(4) conspiring or colluding with any other person to defraud the United States or any local, county or State government; or

(5) knowingly making opportunity for any person to defraud the United States; or

(6) doing or omitting to do any act with intent to enable any other person to defraud the United States or any local, county or State government; or

(7) making or signing any fraudulent entry in any book, or making or signing any application, form or statement, knowing it to be fraudulent; or

(8) having knowledge or information of the violation of any provision of the welfare statute which constitutes fraud against the welfare system, and failing to report such knowledge or information to the appropriate official; or

(9) demanding, or accepting, or attempting to collect, directly or indirectly as payment or gift, or otherwise, any sum of money or other thing of value for the compromise, adjustment, or settlement of any charge or complaint for any violation or alleged violation of law, except as expressly authorized by law.

In addition to these penalties the employee involved shall be dismissed from office or discharged from employment.

LIMITING HEW REGULATORY AUTHORITY IN WELFARE PROGRAMS

The Social Security Act permits the Secretary of Health, Education, and Welfare to "Make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions" with which he is charged under the Act. Similar authority is provided under each of the welfare programs. Particularly since January, 1969, regulations have been issued under this general authority with little basis in law and which sometimes have run directly counter to legislative history. Many States have attributed at least a part of the growth of the welfare caseload in recent years to these regulations of the Department of HEW.

A number of committee decisions deal with problems raised by specific HEW regulations. In addition, the committee agreed to modify the statutory language quoted above by limiting the Secretary's regulatory authority under the welfare programs so that he may issue regulations only, with respect to specific provisions of the Act and even in these cases the regulations may not be inconsistent with these provisions.

DEMONSTRATION PROJECTS TO REDUCE DEPENDENCY ON WELFARE

The Social Security Act currently authorizes appropriations for research and demonstration projects in the area of public assistance and social services. The authority has been used to fund several guaranteed minimum income experiments and also a large number of projects related to providing social services to welfare recipients. The

committee agreed to place emphasis on those programs helping persons to become economically independent by requiring that one-half of the funds spent under these two sections be spent on projects relating to the prevention and reduction of dependency on welfare, rather than welfare expansion.

2. CHILD WELFARE SERVICES

GRANTS TO STATES FOR CHILD WELFARE SERVICES (INCLUDING FOSTER CARE AND ADOPTIONS)

The committee adopted an amendment increasing the annual authorization for Federal grants to the States for child welfare services to \$200 million in fiscal year 1973, rising to \$270 million in 1977 and thereafter. For fiscal year 1973, this is \$154 million more than the \$46 million which has been appropriated every year since 1967. The committee anticipates that a substantial part of any increased appropriation under this higher authorization will go towards meeting the costs of providing foster care which now represents the largest single item of child welfare expenditure on the county level. The committee, however, avoided earmarking amounts specifically for foster care so that wherever possible the State and counties could use the additional funds to expand preventive child welfare services with the aim of helping families stay together and thus avoiding the need for foster care. The additional funds can also be used for adoption services, including action to increase adoptions of hard-to-place children.

NATIONAL ADOPTION INFORMATION EXCHANGE SYSTEM

The committee bill would authorize \$1 million for the first fiscal year and such sums as may be necessary for succeeding fiscal years for a Federal program to help find adoptive homes for hard-to-place children. The amendment would authorize the Secretary of Health, Education, and Welfare to "provide information, utilizing computers and modern data processing methods, through a national adoption information exchange system, to assist in the placement of children awaiting adoption and in the location of children for persons who wish to adopt children, including cooperative efforts with any similar programs operated by or within foreign countries, and such other related activities as would further or facilitate adoption."

3. OTHER PROVISIONS

EVALUATION OF PROGRAMS UNDER THE SOCIAL SECURITY ACT

The committee bill assigns to the General Accounting Office the basic role of evaluating programs under the Social Security Act. In addition, the amendment would not permit any Federal agency to enter into a contract to evaluate any program under the Social Security Act (if an expenditure of more than \$25,000 is involved) unless the Comptroller General approves the study in advance. His approval would be conditioned on his determination that:

- (a) The conduct of such study or evaluation of such program is justified;

(b) The department or agency cannot effectively conduct the study or evaluation through utilization of regular full-time employees; and

(c) The study or evaluation will not be duplicative of any study or evaluation which is being conducted, or will be conducted within the next twelve months, by the General Accounting Office.

USE OF FEDERAL FUNDS TO UNDERMINE FEDERAL PROGRAMS

Another amendment approved by the committee would prohibit the use of Federal funds to pay, directly or indirectly, the compensation or expenses of any individual who in any way participates in action relating to litigation which is designed to nullify Congressional statutes or policy under the Social Security Act. This prohibition may, however, be waived by the Attorney General 60 days after he has provided the Committee on Finance and the Committee on Ways and Means with notice of his intent to waive the prohibition. This will allow the committees time to take legislative action if appropriate. This amendment is similar to one approved by the committee in 1970 as part of the Social Security-Welfare bill of that year—a bill which was not finally enacted.

APPOINTMENT AND CONFIRMATION OF ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICES

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities at present are broad, encompassing the federally aided welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge; the bulk of the \$14-billion 1972 budget for the agency is spent on the public assistance and medicaid programs. The committee agreed to upgrade the stature of the Administrator of the Social and Rehabilitation Service by having the President select him and by having him confirmed by the Senate as his colleagues with equivalent positions in the Department (the Commissioner of Social Security, the Commissioner of Education, and the Surgeon General) now are.

G. Child Care

At the present time, the lack of availability of adequate child care today represents perhaps the greatest single obstacle in the efforts of poor families, especially those headed by a mother, to work their way out of poverty. It also represents a hindrance to those mothers in families above the poverty line who wish to seek employment for their own self-fulfillment or for the improvement of their family's economic status.

The Committee on Finance has long been involved in issues relating to child care. The committee has been dealing with child care as a segment of the child welfare program under the Social Security Act since the original enactment of the legislation in 1935. Over the years, authorizations for child welfare funds were increased in legislation acted on by the committee.

As part of its continuing concern for the welfare of families with children who are in need, and in order to provide for the expansion of child care required to enable the new employment program to meet its goal of making present AFDC recipients independent, the committee is proposing a new approach to the problem of expanding the supply of child care services and improving the quality of these services. The committee bill thus establishes within the new Work Administration a Bureau of Child Care with the eventual goal of making child care services available throughout the Nation to the extent they are needed, but are not supplied under other programs.

BUREAU OF CHILD CARE

The Bureau of Child Care would have as its first priority making available child care services to participants in the employment program. Next in order of priority would be the provisions of child care to low-income working mothers and to other mothers desiring child care services.

Where child development services are available under any other legislation approved by the Congress, the Bureau would attempt to place children in those services.

To the maximum extent possible, the Bureau would attempt to utilize mothers participating in the employment program in providing child care services.

Initially, the Bureau would train persons to provide family day care and would contract with existing public, private non-profit, and proprietary facilities to serve as child care providers. To expand services, the Bureau would also give technical assistance and advice to organizations interested in establishing facilities under contract with the Bureau. In addition, the Bureau could provide child care services in its own facilities.

Federal child care standards are specified in the amendment to assure that adequate space, staff and health requirements are met. In

addition, facilities used by the Bureau will have to meet the Life Safety Code of the National Fire Protection Association. Any facility in which child care is provided by the Bureau, either directly or by contract, will have to meet the Federal standards, but will not be subject to any licensing or other requirements imposed by States or localities. This provision will make it possible for many groups and organizations to establish child care facilities under contract with the Bureau where they cannot now do so because of overly rigid State and local requirements.

Subsidization of child care for low-income working mothers will depend on the availability of appropriations. Mothers able to pay will be charged the full cost of services.

In addition to appropriations to subsidize child care costs for low-income working mothers, fees would be charged for services provided or arranged for by the Bureau. They would be set at a level which would cover the unsubsidized costs of arranging for child care. The fees would go into the revolving fund to provide capital for further expansion of services.

The child care amendment also includes provision to authorize the Bureau to issue bonds for construction if, after the first two years of operation, the Bureau feels that additional funds for capital construction of child care facilities are needed. Up to \$50 million in bonds could be issued each year, with an overall limit of \$250 million on bonds outstanding.

AUTHORIZATION

The committee agreed to authorize \$800 million in fiscal year 1973 (and such sums as the Congress might appropriate thereafter) to arrange for and to pay for part or all of the cost of child care for the children of participants in the employment program and to other low income working mothers. (The House bill would provide \$750 million for substantially the same purposes.)

GRANTS TO STATES FOR ESTABLISHMENT OF MODEL DAY CARE

The committee expects that much of the child care offered by the Bureau of Child Care will be similar to that provided by mothers in their own home, since experience has shown that most working mothers prefer family day care because of its convenience and its informality. However, the committee has also provided a 3-year program of grants to States to permit them to develop model child care. Appropriations would be authorized to permit each State in fiscal years 1973, 1974 and 1975 to receive a grant of up to \$400,000 per year to pay all or part of the cost of model care, whether through the establishment of one child care center or a child care system. Special emphasis would be placed on utilizing the model child care for training persons in the field of child care.

H. Aid to Families With Dependent Children

WELFARE AS A STATUTORY RIGHT

A number of court cases in recent years have been based on the view that welfare is a property right rather than a gratuity provided for under a statute. The committee agreed to make clear in the statute that welfare is a statutory right granted under law which can be extended, restricted, altered, amended or repealed by law. It is distinct from a property right or any right considered inviolate under the Constitution.

USE OF SOCIAL SECURITY NUMBERS AND OTHER MEANS OF IDENTIFICATION

The committee bill would require the use of social security numbers in the administration of assistance programs. States would use social security numbers for case file identification, for cross-checking purposes and as an aid in the compilation of statistical data with respect to the welfare programs. In addition, States would be authorized to use photographs and such other means of identification as they desire in administering the welfare programs, as well as setting penalties for misuse of these means of identification.

SEPARATION OF SERVICES AND ELIGIBILITY DETERMINATION

An example of HEW efforts at legislation through regulation involves the separation of social services from the welfare payment process. On June 2, 1972, the Department of HEW issued a regulation requiring States to have completely separate administrative units handling the provision of social services and handling the determination of eligibility for welfare. The issuing of this regulation was justified on the grounds that the Family Assistance Plan in the House-passed bill would soon be enacted and it would require a separation of the State-administered services program from the Federal welfare payment programs. Under the committee bill States would not be required to separate the provision of social services from the determination of eligibility for welfare.

FURNISHING MANUALS AND OTHER POLICY ISSUANCES

Regulations issued by the Department of Health, Education, and Welfare in October, 1970, require States to make available current copies of program manuals and other policy issuances without charge to public or university libraries, the local or district offices of the Bureau of Indian Affairs, and welfare or legal services offices or organizations. The material may also be made available, with or without

charge, to other groups and to individuals. The committee approved an amendment under which States would be permitted to be reimbursed for the cost (but no more than the cost) of making this information available.

PERSONS ELIGIBLE FOR AID TO FAMILIES WITH DEPENDENT CHILDREN

The committee bill, when the Guaranteed Employment program goes into effect on January 1, 1974, will require that States:

1. Make eligible for AFDC only the following classes of families:
 - a. Family headed by mother with child under age 6;
 - b. Family headed by incapacitated father where mother is not in the home or is caring for father;
 - c. Family headed by mother who is ill, incapacitated, or of advanced age;
 - d. Families headed by mother too remote from an employment program to be able to participate;
 - e. Family headed by mother attending school fulltime even if there is no child under 6; and
 - f. Child living with neither parent, together with his caretaker relative(s), providing his mother is not also receiving welfare; and
2. Do not reduce payment levels to AFDC recipients below \$1,600 for a two-member family, \$2,000 for a three-member family and \$2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

This requirement is not intended to act as a limitation on the right of a State to make other persons eligible at its own expense for benefits under its AFDC program. Indeed, in many States with benefit levels higher than those provided under the guaranteed employment program, AFDC-type families participating in the work program would receive supplemental payments under the State program sufficient to bring their incomes up to the payment standards generally applicable in the State. Specifically, the families not required to be covered by the State program (although it can be anticipated that many States will continue to supplement them) are families headed by an able-bodied male and families headed by an able-bodied female if all her children have reached age 6.

DEFINITION OF "INCAPACITY" UNDER AID TO FAMILIES WITH DEPENDENT CHILDREN

Under present law the Federal Government will match payments to families where the father is incapacitated. The definition of "incapacitated" is left up to the States. Under the committee bill the term "incapacitated" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." This is the same definition as is used in determining disability under the social security disability insurance program, except that the definition suggested would also apply to short term, temporary disability while social security benefits are available only to persons whose disability will last at least 12 months.

DURATION OF RESIDENCY

The committee agreed to require States to establish a three-month duration of residence requirement in order to be eligible for welfare. If a welfare recipient in one State moves to another State, the State of origin would continue making the welfare payments for three months; however, no State would be required to make welfare payments more than 90 days after an individual has left the State.

The committee also agreed with the provision in the House-passed version of H.R. 1 that would make an individual ineligible for welfare payments during any month in which the person is outside the United States the entire month; once an individual has been outside the United States for at least 30 consecutive days, he must remain in the United States for 30 consecutive days before he may again become eligible for welfare.

In addition, to become eligible for welfare, an individual must be a resident of the United States and either a citizen or alien lawfully admitted for permanent residence or a person who is a resident under color of law.

WELFARE PAYMENTS FOR RENT

Under existing law welfare payments are ordinarily made directly to the recipients. Some States have indicated that they could effect substantial administrative savings if they were permitted to make a single payment directly to public housing authorities of the rent portion of welfare payments for recipients in public housing. The committee bill would permit States to do this. It would also permit State welfare agencies to make a vendor payment for rent directly to a landlord provided that (a) the welfare recipient has failed to make rent payments (whether or not to the same landlord) for two consecutive months, and (b) the landlord agrees to accept the amount actually allowed by the State to the recipient for shelter as total payment for the rent. The committee also agreed to repeal a welfare amendment in Public Law 92-213 which would require welfare agencies in some circumstances to pay as a rental allowance more than the actual cost of rent.

ALCOHOLICS AND ADDICTS

The committee was concerned over the fact that many thousands of recipients on welfare who have been determined to be alcoholics and addicts are not being provided necessary rehabilitative care and treatment. For explanation of committee amendments related to care and treatment of these persons, see the end of the section on medicare and medicaid provisions.

SHARING THE COST OF PROSECUTING WELFARE FRAUD

Under present law, the Federal Government pays 50 percent of the cost of administration of the welfare programs, as these costs are incurred by the State welfare agency. The committee bill extends an amendment providing 50 percent Federal matching also for the cost of State and local prosecuting attorney efforts to prosecute welfare fraud.

RECENT DISPOSAL OF ASSETS

Under present law, an individual with assets whose value exceeds the welfare eligibility level in the State, may dispose of those assets in order to qualify for assistance.

The committee bill deals with this situation by providing that anyone who has voluntarily assigned or transferred property to a relative within one year prior to applying for public assistance and who has received less than fair market value for the property, will be ineligible for public assistance for a one year period commencing with the date of transfer.

INELIGIBILITY OF STRIKERS

Until January 1, 1974, States would continue to be permitted to make eligible for AFDC children whose fathers are unemployed. However, a father would be disqualified if he were a striker. This disqualification would not apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off workers because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the government financing one side of a labor-management dispute.

INELIGIBILITY OF UNBORN CHILDREN

Regulations of the Department of Health, Education, and Welfare permit Aid to Families with Dependent Children payments for a child who has not yet been born. The committee bill would make unborn children ineligible for AFDC.

CHILDREN LIVING IN A RELATIVE'S HOME

Under the present law an AFDC mother with more than one child can enable a relative to become eligible for welfare by lending the relative one of her children. The committee bill would permit a State to deny welfare aid to the relative in such situation.

COÖPERATION OF MOTHER IN IDENTIFYING THE FATHER AND SEEKING SUPPORT PAYMENTS

The committee bill would require, as a condition of eligibility, that a mother cooperate in efforts to establish the paternity of a child born out of wedlock, cooperate in seeking support payments from the father, and assign the right to collect support payments on her behalf to the Government.

The provisions related to child support and establishing paternity are described in greater detail under the heading "Child Support."

FAMILIES WHERE THERE IS A CONTINUING PARENT-CHILD
RELATIONSHIP

The committee has approved a provision which would clarify congressional intent with respect to the meaning of the term "parent" under the AFDC program. In most cases, AFDC families are eligible on the basis that the children in the family have been deprived of parental support by reason of the continued absence from the home of a parent. In 1968, the Supreme Court ruled that a State could not consider a child ineligible for AFDC when there is a substitute father with no legal obligation to support the child. This court decision was based on an interpretation that Congress did not intend that such a person would come within the meaning of the term "parent." The committee bill would allow States to deny welfare payments to a child living in the same household as his stepfather. The bill would also authorize States to determine whether a man is a "parent" on the basis of a total evaluation of his relationship with the child and not solely on the question of his obligation to support. The determination would have to consider the following indications of the existence of a parental relationship:

1. The individual and the child are frequently seen together in public;
2. The individual is the parent of a half-brother or half-sister of the child;
3. The individual exercises parental control over the child;
4. The individual makes substantial gifts to the child or to members of his family;
5. The individual claims the child as a dependent for income tax purposes;
6. The individual arranges for the care of the child when his mother is ill or absent from the home;
7. The individual assumes responsibility for the child when there occurs in the child's life a crisis such as illness or detention by public authorities;
8. The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;
9. The individual makes frequent visits to the place of residence of the child; and
10. The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

The relationship between an adult individual and a child would be determined to exist in any case only after an evaluation of the factors as well as any evidence which may refute any inference supported by evidence related to such factors.

Under the committee bill, the use of this provision would be optional with the States. If a State affirmatively exercised its option, however, it would have to comply with this method in determining the child-father relationship.

DENIAL OF WELFARE FOR REFUSAL TO ALLOW CASEWORKER IN HOME

In 1969 a Federal District Court ruled on constitutional grounds that a State could not terminate welfare payments to a recipient who refused to allow a caseworker in her home. In 1971, the Supreme Court reversed the lower court's decision. The committee agreed to codify the Supreme Court's decision in the statute by amending the Act to permit a State to require as a condition of eligibility for welfare that a recipient allow a caseworker to visit the home at a reasonable time and with reasonable advance notice.

DECLARATION METHOD OF DETERMINING ELIGIBILITY

Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant's home and from other sources. For persons found eligible for assistance, re-determination of eligibility is required at least annually, and similar procedures are followed.

The Department of Health, Education, and Welfare has required States to use a simplified or "declaration method" for aid to aged, blind, and disabled, and has strongly urged that this method be used in the program of Aid to Families with Dependent Children. The simplified or "declaration method" provides for eligibility determinations to be based to the maximum extent possible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the caseworker. The committee bill precludes the use of the declaration method by law. It also explicitly authorizes the States in the statute to examine the application or current circumstances and promptly make any verification from independent or collateral sources necessary to insure that eligibility exists. The Secretary could not, by regulation, limit the State's authority to verify income or other eligibility factors.

RECOUPING OVERPAYMENTS

The committee agreed to provide statutorily that overpayments constitute an obligation of an individual to be withheld from any future assistance payments or any amounts (other than Social Security death benefits) owed by the Federal Government to the individual; in addition, overpayments could be collected through ordinary collection procedures.

INELIGIBILITY FOR FOOD STAMPS

Under the committee bill (as under the House version), individuals in the welfare programs will not be eligible for food stamps or surplus commodities. States would be assured that there would be no additional expenses to them if they adjust their welfare payment levels to take into account loss of entitlement for food stamps, so that recipients would suffer no loss of income as a result of losing entitlement to food stamps.

INCOME DISREGARDED

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first \$30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full time at wages well above the poverty line.

Until the committee's new employment program becomes effective in January, 1974, the earnings disregard formula would be modified by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). States would be required to disregard the first \$60 earned monthly by an individual working full time (\$30 for an individual working part time) plus one-third of the next \$300 earned plus one-fifth of amounts earned above this. This differential between full time and part time employment is designed to encourage those who are able to move into full time jobs.

In addition, \$20 of child support payments to a family would be disregarded to insure that a family receives a financial benefit when efforts to collect child support are successful.

Once the employment program under the committee bill becomes effective, however, these earned income exemptions under the residual welfare program would be replaced by a flat monthly exemption of \$20, applicable to all kinds of income (with a separate \$20 disregard applicable to child support payments). It would be expected that mothers interested in working would receive their work incentives through participating in the employment program rather than by remaining on welfare.

In order to prevent the State welfare program from undermining the objectives of the Federal employment program, the States would have to assume for purposes of supplemental payments provided under AFDC or any welfare program that individuals, who are eligible to participate in the employment program (but no longer eligible to receive their basic income from AFDC), are actually participating full time in the employment program and thus receiving \$200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Futhermore, the State would be required to disregard any earnings between \$200 a month and \$375 a month (the amount an employee would earn working 40 hours a week at \$2.00 per hour) to ensure that the incentive system of the workfare program is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of \$200 will be attributed to

him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at \$1.50 per hour.

The table below shows how wages under the employment program would be treated for State welfare purposes:

Hours worked per week.....	None	20	32	40
Hourly wage.....		\$1.50	\$1.50	\$2.00
Approximate actual monthly income.....	0	\$130	\$200	\$375
Income deemed available for State welfare purposes.....	\$200	\$200	\$200	\$200

ASSISTANCE LEVELS

Under existing law, each State decides the level of assistance it will provide for AFDC families. The committee bill generally reaffirms the right of the State to make this determination. In moving to a block grant approach which involves substantial fiscal relief, however, the committee feels it is appropriate to require that States could not reduce payments levels to AFDC recipients below \$1,600 for a two-member family, \$2,000 for a three-member family, and \$2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

RIGHT TO APPLY FOR AID AND TO RECEIVE IT WITH REASONABLE PROMPTNESS

The present law requires that :

All individuals wishing to make application for Aid to Families with Dependent Children shall have opportunity to do so, and that Aid to Families with Dependent Children shall be furnished with reasonable promptness to all eligible individuals.

The committee bill would reiterate this provision, but would make clear the requirement that aid be furnished "with reasonable promptness" could not be so construed as to interfere with other requirements of the law such as seeking a mother's cooperation in establishing paternity and seeking support payments, or verifying information on income, resources and other eligibility factors.

APPEALS PROCESS

Present law requires that a State plan must provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid is denied or not acted upon with reasonable promptness.

On March 23, 1970, the Supreme Court ruled in two cases (*Goldberg v. Kelly* (397 U.S. 254) and *Wheeler v. Montgomery* (397 U.S. 280)) that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The decision was made on the constitutional grounds that termination of payments before such a hearing would violate the due process clause. The Court argued that welfare payments are a matter of statutory entitlement for per-

sons qualified to receive them, and that "it may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.' * * * The constitutional challenge cannot be answered by an argument that public assistance benefits are 'a "privilege" and not a "right."'"

The HEW regulations based on the court's decision (45 CFR 205.10) go much further than the court in spelling out the requirements for fair hearings. The tone and emphasis of the regulations is shown in these excerpts: "Agency emphasis must be on helping the claimant to submit and process his request, and in preparing his case, if needed. The welfare agency must not only notify the recipient of his right to appeal, it must also notify him that his assistance will be continued during the appeal period if he decides to appeal." The regulation continues: "prompt, definitive, and final administrative action will be taken within 60 days from the date of the request for a fair hearing, *except where the claimant requests a delay in the hearing*" (emphasis added).

The committee bill deals with this situation by requiring State welfare agencies to reach a final decision on the appeal of a welfare recipient within 30 days following the day the recipient was notified of the agency's intention to reduce or terminate assistance. The bill would also require the repayment to the agency of amounts which a recipient received prior to the appeal decision if it was determined that the recipient was not entitled to them. Any amounts not repaid would be considered an obligation of the recipient and would be recouped in the same manner as other overpayments. In addition, the committee bill would stipulate that the recipient has a right to appeal at a higher administrative level but that payments need not be continued once an initial adverse determination has been made on the local level at a hearing at which evidence can be presented.

The committee provision was designed to assure that the appeals procedures would be handled expeditiously by the State and also to assure that appeals would not be made frivolously.

SAFEGUARDING INFORMATION

The statutes in all of the welfare programs under the Social Security Act provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of each welfare program. Regulations issued by the Department of Health, Education, and Welfare state that the same policies apply to requests for information from a governmental authority, the courts or law enforcement officials as from any other outside source.

The committee bill re-enacts these statutory provisions for AFDC but includes features making it clear that this requirement may not be used to prevent a court, prosecuting attorney, tax authority, law enforcement official, legislative body or other public official from obtaining information in connection with his official duties including the collection of support payments or prosecuting fraud or other criminal or civil violations.

COMMUNITY WORK AND TRAINING PROGRAMS

Prior to the enactment of the Work Incentive Program as part of the 1967 Social Security Amendments, the Federal statute permitted Federal matching of AFDC payments made to recipients participating in a community work training program. Since the enactment of the Work Incentive Program, however, the Department of Health, Education, and Welfare has taken the position that the Federal Government will not share in AFDC payments to recipients who are required by State law to participate in an employment program—unless the program is part of the Work Incentive Program. The committee bill provides that during the period between enactment of the House bill and the effective date of the new Federal employment program, the community work training provisions in the law prior to the 1967 amendments would be applied so that States wishing to have such programs in the interim could do so.

PROTECTIVE PAYMENTS FOR CHILDREN

The committee bill requires States under the AFDC program to take certain actions to assure that welfare payments are being used in the best interests of children. Existing law provides that when the welfare agency has reason to believe that the AFDC payments are not used in the best interests of the child, it "may" provide counseling and guidance services so that the mother will use the payments in the best interests of the child. This failing, the agency "may" resort to protective payments to a third party who will use the funds for the best interest of the child. The committee bill makes these procedures mandatory in such cases.

REQUIREMENT FOR STATEWIDENESS FOR SOCIAL SERVICES

The Social Security Act requires that social services (including child care and family planning services) under the welfare programs be in effect in all political subdivisions of a State in order for the State to obtain Federal matching funds. This requirement of state-wideness has sometimes delayed the provision of these services. The committee agreed to permit the Secretary to waive the requirement of state-wideness for services.

SOCIAL SERVICES

The Committee also approved an amendment to limit Federal funding for social services.

The Committee amendment is similar to the measure the Congress will soon be acting upon in connection with the State and Local Fiscal Assistance Act of 1972.

Under the amendment, Federal matching for social services to the aged, blind and disabled, and those provided under Aid to Families With Dependent Children would be subject to a State-by-State dollar limitation, effective beginning fiscal year 1973. Each State would be limited to its share of \$2,500,000,000 based on its proportion of population in the United States. Child care, family planning, services pro-

vided to a mentally retarded individual, services related to the treatment of drug addicts and alcoholics, and services provided a child in foster care could be provided to persons formerly on welfare or likely to become dependent on welfare as well as present recipients of welfare. At least 90 percent of expenditures for all other social services, however, would have to be provided to individuals receiving aid to the aged, blind, and disabled (or supplemental security income), care and treatment for drug addiction or alcoholism, or aid to families with dependent children. Until a State reaches the limitation on Federal matching, 75 percent Federal matching would continue to be applicable for social services as under present law.

Under the amendment, services necessary to enable AFDC recipients to participate in the Work Incentive Program would not be subject to the limitation described above; they would continue as under present law, with 90 percent Federal matching and with funding of these services limited to the amounts appropriated. In addition, Federal matching for emergency social services would be reduced from 75 percent to 50 percent.

FAMILY PLANNING SERVICES

The committee approved payment by the Federal Government of 100 percent of the cost of Family Planning Services as compared with 75 percent under present law. Funding for family planning would not be subject to the \$2.5 billion limitation.

ELIMINATE STATUTORY REQUIREMENT OF INDIVIDUAL PROGRAM OF SERVICES FOR EACH FAMILY

Present law requires States to develop an individual program of services for each family receiving AFDC. This has proven to be an unnecessary administrative burden. The committee agreed to delete this statutory requirement.

SUPPORTIVE SERVICES FOR PARTICIPANTS IN THE WIN PROGRAM

Until the Government Employment Program begins on January 1, 1974, the committee bill would continue 90 percent Federal matching for supportive services other than family planning services to enable AFDC recipients to participate in the Work Incentive Program.

EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES WITH CHILDREN

Under existing law, emergency assistance may, at the option of the States, be provided to needy migrant families in crisis situations, and it may be provided either statewide or in part of the State. Emergency assistance programs have been adopted in about half of the States, and they receive 50 percent Federal matching. Under the law, assistance may be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide living arrangements for the child. The committee bill (1) requires that all States have a program of emergency assistance to migrant families with children; (2) requires that the

program be statewide in application; and (3) provides 75 percent Federal matching for emergency assistance to migrant families.

MAKING ESTABLISHMENT OF ADVISORY COMMITTEE OPTIONAL

Regulations issued by the Department of Health, Education, and Welfare in 1969 require States to establish a welfare advisory committee for AFDC and child welfare programs "at the State level and at local levels where the programs are locally administered," with the cost of the advisory committees and their staffs borne by the States (with Federal matching) as part of the cost of administering the welfare programs. The committee bill makes the establishment of such committees optional with the States.

ADMINISTRATIVE COSTS

The committee agreed that the Federal Government would continue to pay 50 percent of the cost of administration of the AFDC program including administrative costs related to the provision of Social Services.

FEDERAL FINANCIAL PARTICIPATION IN WELFARE PAYMENTS

The committee bill would make a major change in the basic method of Federal funding for AFDC by providing a block Federal grant with substantially more Federal funds than are now provided under present law. This approach is described in detail under the heading "Fiscal Relief for States."

TABLE 7.—RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN, DECEMBER OF SELECTED YEARS

Year	Number of recipients	Percent increase since 1960
1940.....	1,222,000	
1945.....	943,000	
1950.....	2,233,000	
1955.....	2,192,000	
1960.....	3,073,000	
1961.....	3,566,000	+16
1962.....	3,789,000	+24
1963.....	3,990,000	+28
1964.....	4,219,000	+38
1965.....	4,396,000	+44
1966.....	4,666,000	+52
1967.....	5,309,000	+73
1968.....	6,086,000	+98
1969.....	7,313,000	+138
1970.....	9,659,000	+215
1971.....	10,651,000	+247
1972 ¹	12,573,000	+311
1973: ¹		
Current law.....	13,800,000	+349
Committee bill..... ²	13,800,000	+349
1974: ¹		
Current law.....	14,900,000	+385
Committee bill: persons eligible to receive basic income from AFDC..... ³	8,940,000	+191

¹ Estimated.

² Some reduction of caseload may be anticipated because of committee amendments related to eligibility rules and administration; the extent of the reduction will largely depend upon State action.

³ Reflects estimate that about 40 percent of current caseload will no longer be eligible to get basic income from AFDC.

Source: Department of Health, Education, and Welfare.

Statistical Material

**TABLE 8.—AID TO FAMILIES WITH DEPENDENT CHILDREN:
INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST
AMOUNT PAID TO FAMILY OF 4, BY STATE, JULY 1972**

	Income eligibility level for payments	Largest amount paid for basic needs
Alabama.....	\$230	\$97
Alaska.....	400	300
Arizona.....	266	173
Arkansas.....	210	106
California.....	280	280
Colorado.....	235	235
Connecticut.....	335	335
Delaware.....	287	158
District of Columbia.....	245	245
Florida.....	223	145
Georgia.....	158	149
Hawaii.....	268	268
Idaho.....	278	278
Illinois.....	273	273
Indiana.....	355	175
Iowa.....	243	243
Kansas.....	322	322
Kentucky.....	193	193
Louisiana.....	114	114
Maine.....	349	168
Maryland.....	200	200
Massachusetts.....	318	318
Michigan.....	316	316
Minnesota.....	324	324
Mississippi.....	277	60
Missouri.....	313	130
Montana.....	206	206
Nebraska.....	274	226
Nevada.....	176	176
New Hampshire.....	294	294
New Jersey.....	324	324
New Mexico.....	203	179
New York.....	333	333
North Carolina.....	172	172
North Dakota.....	300	300

**TABLE 8.—AID TO FAMILIES WITH DEPENDENT CHILDREN:
INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST
AMOUNT PAID TO FAMILY OF 4, BY STATE, JULY 1972—
Continued**

	Income eligibility level for payments	Largest amount paid for basic needs
Ohio.....	\$200	\$200
Oklahoma.....	189	189
Oregon.....	243	243
Pennsylvania.....	301	301
Rhode Island.....	255	255
South Carolina.....	208	104
South Dakota.....	270	270
Tennessee.....	217	132
Texas.....	148	148
Utah.....	235	235
Vermont.....	319	319
Virginia.....	261	261
Washington.....	290	290
West Virginia.....	146	146
Wisconsin.....	311	311
Wyoming.....	260	227

Source: Department of Health, Education, and Welfare.

I. Child Support

The committee has long been aware of the impact of deserting fathers on the rapid and uncontrolled growth of families on AFDC. As early as 1950, the Congress provided for the prompt notice to law enforcement officials of the furnishing of AFDC with respect to a child that had been deserted or abandoned. In 1967, the committee instituted what it believed would be an effective program of enforcement of child support and determination of paternity. Due to a total lack of leadership by the Department of HEW, most States have not implemented these provisions in a meaningful way. The committee believes, therefore, that a new legislative thrust is required in this area which will create a mechanism to obtain compliance with the law. The major elements of this proposal have been adapted from those States which have been the most successful in establishing effective programs of child support and determination of paternity. Some of the modes of assistance which are created by the committee plan will be available to deserted families generally, regardless of welfare status. It is hoped that making these provisions available to all deserted families will prevent further expansion of the welfare rolls.

Present law requires that the State welfare agency establish a separate, identified unit whose purpose is to undertake to determine the paternity of each child receiving welfare who was born out of wedlock, and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for him from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to both Social Security and (if there is a court order) to Internal Revenue Service records in locating deserting parents. The effectiveness of the provisions of present law have varied widely among the States.

ASSIGNMENT OF RIGHT TO COLLECTION OF SUPPORT PAYMENTS

In some instances, mothers may have personal reasons for fearing to cooperate in identifying and securing support payments from the father of the child. To protect the mother, and also to allow for a more systematic approach for the collection of support payments, the committee approved an amendment requiring a mother, as a condition of eligibility for welfare, to assign her right to support payments to the Government and to require her cooperation in identifying and locating the father and in obtaining any money or property due the family or Government. The assignment of family support rights would be to the Federal Government, and the Department of Justice would

be authorized to delegate these rights to those States which have effective programs of determining paternity and obtaining child support. The Attorney General would also be authorized to delegate such collection rights to counties that have effective programs, but only if the State as a whole did not.

If the Attorney General found that a State did not have an effective program, the collection rights would remain with the Federal Government and would be enforced by Federal attorneys in either State or Federal Courts. OEO lawyers would be made available to assist Justice Department attorneys in carrying out their responsibility. In this situation the Federal Government would retain the full amount not payable to the family.

The House bill provided that the Federal share for State expenses for establishing paternity and securing support should be increased from 50 to 75 percent. The committee adopted this provision, but with a proviso that there be no Federal participation in such State programs which do not meet the Attorney General's standards of effectiveness.

LOCATING A DESERTING PARENT; ACCESS TO INFORMATION

Under the committee bill, the State or local Government would proceed to locate the absent parent, using any information available to it, such as the records of the Internal Revenue Service and the Social Security Administration. The committee bill extends access to these Federal records to any parent seeking support from a deserting spouse regardless of whether the family was on welfare. Non-welfare families desiring to use this means of finding the absent parent would make the necessary application at local welfare offices. The Federal Government would have to be reimbursed for the cost of these services by the welfare agency or the individual if a welfare case was not involved.

As a further aid in location efforts, welfare information now withheld from public officials, under regulations concerning confidentiality, would be made available by the committee bill; this information would also be available for other official purposes.

INCENTIVES FOR STATES AND LOCALITIES TO COLLECT SUPPORT PAYMENTS

Under present law, when a State or locality collects support payments owed by a father, the Federal Government is reimbursed for its share of the cost of welfare payments to the family of the father; the Federal share currently ranges between 50 percent and 83 percent, depending on State per capita income. In a State with 50 percent Federal matching, for example, the Federal Government is reimbursed \$50 for each \$100 collected, while in a State with 75 percent Federal matching the Federal Government is reimbursed \$75 for each \$100 collected.

Consistent with the committee's block-grant approach for AFDC, and as an incentive for the development of effective State and local programs, the committee bill provides that the entire amount of any savings in welfare payments from support collections would remain with the States. If, however, the actual collection and determination of paternity mechanism is carried out by local authority, the State

would pay 25 percent of the governmental share of the support collections for a 12-month period to such authority.

In the situation where the location of runaway parents and the enforcement of support orders is carried out by a State other than that in which the deserted family resides, the State or local authority which actually carries out the location and enforcement functions will be paid the 25 percent bonus.

The committee bill provides, that the Federal Government would have to be reimbursed for any Federal costs incurred by the States and localities in their collection and determination of paternity efforts.

VOLUNTARY APPROACH

The committee expects that most States will find it desirable to encourage parents to enter into voluntary arrangements for making regular support payments; legal action would be used to the extent that voluntary agreements have proven or are likely to prove unsuccessful. The use of the voluntary agreement can avoid the need for court action and formal collection procedures. The record of the State of Washington in collecting support payments voluntarily was highlighted in a recent study by the General Accounting Office as a key element in their support collection program; hopefully, the experience of Washington State can serve as a model for all States.

CIVIL ACTION TO OBTAIN SUPPORT PAYMENTS

Where the voluntary approach is not successful, the committee's bill provides for strong legal remedies. The States, as agents of the Federal Government, in enforcing the support rights assigned to them by welfare applicants would have available to them all the enforcement and collection mechanisms available to the Federal Government, including the use of the Internal Revenue Service to garnishee the wages of the absent parent. If these mechanisms are utilized the Federal Government would have to be reimbursed on a cost basis.

DISTRIBUTION OF COLLECTIONS

The first \$20 of any support collected in a month will be disregarded and the remainder will be used to offset or reduce the AFDC payment to the family for the month. If the support payment is sufficient to entirely offset the family's AFDC eligibility for the month, the entire support payment up to the amount of the family's support needs under a court order or voluntary agreement will go to the family and any excess will be returned to the State as a reimbursement for past welfare payments.

RESIDUAL OBLIGATION TO FEDERAL GOVERNMENT

The welfare payment would serve as the basis of a continuing monetary obligation of the deserting parent to the United States. The obligation would be the lesser of the welfare assistance paid to the family, or 50 percent of the deserting spouse's income but not less than \$50 a month.

A waiver of all or part of the Federal obligation might be allowed upon a showing of good cause.

CRIMINAL ACTION

The committee bill has provided for Federal criminal penalties for an absent parent who has not fulfilled his obligation to support his family and the family receives welfare payments in which the Federal Government participates. His obligation to support would be determined by applying State civil and/or criminal law. The sanctions for failure to support could include a penalty of 50 percent of the amount owed or a fine of up to \$1,000 or imprisonment for up to 1 year or a combination of these.

DETERMINING PATERNITY

The committee believes that an AFDC child has a right to have its paternity ascertained in a fair and efficient manner. Although this may in some cases conflict with the mother's short-term interests, the committee feels that the child's right to support, inheritance, and his right to know who his father is deserves the higher social priority. In 1967, Congress enacted legislation requiring the States to establish programs to establish the paternity of AFDC children born out of wedlock so that support could be sought. The effectiveness of this provision was greatly curtailed both by the failure of the Department of Health, Education, and Welfare to exercise any leadership role and also by Court interpretations of Federal law in decisions which prevented State welfare agencies from requiring that a mother cooperate in identifying the father of a child born out of wedlock.

COOPERATION OF MOTHER

The committee has made cooperation in identifying the absent parent a condition for AFDC eligibility. As a further incentive for cooperation, the first \$20 a month in support collections would be disregarded for purposes of determining the amounts of welfare payments to the family. Thus, the family would always be better off if support payments were made by the absent parent.

BLOOD GROUPING LABORATORIES

The committee has also taken additional steps to provide for a more effective system of determining paternity.

First, a father not married to the mother of his child would be required to sign an affidavit of paternity if he agreed to make support payments voluntarily in order to avoid court action. Most States do not permit initiation of paternity actions more than two or three years after the child's birth; the affidavit would serve as legal evidence of paternity in the event that court action for support should later become necessary.

Second, there is evidence that blood typing techniques have developed to such an extent that they may be used to establish evidence of paternity at a level of probability acceptable for legal determinations.

Moreover, if blood grouping is conducted expertly, the possibility

of error can all but be eliminated. Therefore, the committee adopted a provision to authorize and direct the Department of Health, Education, and Welfare to establish or arrange for regional laboratories that can do blood typing for purposes of establishing paternity, so that the State agencies and the courts would have this expert evidence available to them in paternity suits. No requirement would be made in Federal law that blood tests be made mandatory. The services of the laboratories would be available to courts with respect to any paternity proceeding, not just a proceeding brought by, or for, a welfare recipient.

LEADERSHIP ROLE OF JUSTICE DEPARTMENT

To coordinate and lead efforts to obtain child support payments, the committee action would require each U.S. Attorney to designate an assistant who would be responsible for child support. This Assistant U.S. Attorney would assist and maintain liaison with the States in their support collection efforts and would undertake Federal action as necessary. He would be required to submit a quarterly report to Congress concerning child support activities.

The committee bill requires that records be maintained by the Attorney General of the amounts of support collected and of the administrative expenditures incurred in the collection effort and that he submit an annual report to Congress. Amounts collected but not otherwise distributed would be deposited in a separate account which would finance the expenses of the Federal collection efforts. An authorization for an appropriation would be included for the contingency of a deficit in this fund in order to reimburse the Departments of Justice and Treasury for their expenses in this area.

ATTACHMENT OF FEDERAL WAGES

State officials have recommended that legislation be enacted permitting garnishment and attachment of Federal wages and other obligations (such as income tax refunds) where a support order or judgment exists. At the present time, the pay of Federal employees, including military personnel is not subject to attachment for purposes of enforcing court orders, including orders for child support or alimony. The basis for this exemption is apparently a finding by the courts that the attachment procedure involves the immunity of the United States from suits to which it has not consented.

The committee bill would specifically provide that the wages and employment-related annuities of Federal employees including military personnel, and other payments under Federal programs be subject to garnishment in support and alimony cases. This committee amendment would be applicable whether or not the family bringing the garnishment proceeding is on the welfare rolls.

CHILD SUPPORT UNDER WORKFARE

A deserted parent participating in the workfare program could take advantage of the support collection and, where applicable, the paternity determination mechanism provided in the committee bill. The cost of collection, however, would be deducted from the amounts recovered and the balance would be turned over to the deserted family.

EFFECTIVE DATES

Unless otherwise indicated in the bill, new features added by the collection of support and determination of paternity provision would be effective January 1, 1973.

TABLE 9.—AFDC FAMILIES BY PARENTAGE OF CHILDREN, 1971

Parentage	Number	Percent
Total	2,523,900	100.0
Same mother and same father	1,800,200	71.3
Same mother, but 2 or more different fathers	638,400	25.3
Same father, but 2 or more different mothers	5,200	.2
2 or more different mothers and 2 or more different fathers	53,400	2.1
Unknown	26,700	1.1

Source: Department of Health, Education, and Welfare.

TABLE 10.—AFDC FAMILIES WITH SPECIFIED NUMBER OF ILLEGITIMATE RECIPIENT CHILDREN, 1971

Number of children	Number	Percent
Total	2,523,900	100.0
None	1,426,000	56.5
1	559,600	22.2
2	262,400	10.4
3	129,600	5.1
4	71,700	2.8
5	37,300	1.5
6 or more	37,300	1.5

Source: Department of Health, Education, and Welfare.

TABLE 11.—AFDC FAMILIES BY STATUS OF FATHER, 1961,
1967, 1969, AND 1971

Status	Percent of families in—			
	1961	1967	1969	1971
Total.....	100.0	100.0	100.0	100.0
Dead.....	7.7	5.5	5.5	4.3
Incapacitated.....	18.1	12.0	11.5	9.8
Unemployed.....	5.2	5.1	4.8	6.1
Absent from the home:				
Divorced.....	13.7	12.6	13.7	14.2
Legally separated.....		2.7	2.8	2.9
Separated without court decree.....	8.2	9.7	10.9	12.9
Deserted.....	18.6	18.1	15.9	15.2
Not married to mother.....	21.3	26.8	27.9	27.7
In prison.....	4.2	3.0	2.6	2.1
Absent for another reason.....	.6	1.4	1.6	1.2
Subtotal.....	66.7	74.2	75.4	76.2
Other status:				
Stepfather case.....	2.2	1.9	1.9	2.6
Children not deprived of sup- port or care of father, but of mother.....		1.3	.9	.9
Not reported.....			(¹)	.1

¹ Less than 0.05.

Source: Department of Health, Education, and Welfare.

TABLE 12.—AFDC FAMILIES BY WHEREABOUTS OF FATHER,
1971

Whereabouts	Number	Percent
Total.....	2,523,900	100.0
In the home.....	472,900	18.7
In an institution:		
Mental institution.....	8,000	.3
Other medical institution.....	11,200	.4
Prison or reformatory.....	75,300	3.0
Not in the home or an institution; he is residing in:		
Same county.....	469,200	18.6
Different county; same State.....	156,300	6.2
Different State and in the United States.....	230,900	9.1
A foreign country.....	27,100	1.1
Whereabouts unknown.....	959,600	38.2
Inapplicable (father deceased).....	113,400	4.3

Source: Department of Health, Education, and Welfare.

J. Fiscal Relief for States

The committee is well aware that the growth of the welfare rolls since 1967 has been one of the significant factors in bringing about the fiscal crisis currently facing State and local governments. Under the committee bill therefore, the fiscal burden on the States will be substantially decreased through increases in the Federal funding of assistance payments in AFDC and the Federal administration and funding of the supplemental security income program for the aged, blind and disabled, as well as through indirect fiscal relief resulting from improvements which the committee bill makes in the general structure of the welfare programs.

Over the next 2½ years, the bill provides \$3.5 billion in fiscal relief to the States. Of this, \$2.3 billion represents fiscal relief in 1974, the first year the new employment programs are fully effective. The table below shows the detail for each of the years 1972-74.

[Dollars in billions]

	1972	1973	1974	Total
Aid to the aged, blind, and disabled.....			\$0.9	\$0.9
Aid to families with dependent children.....	\$0.4	\$0.8	1.4	2.6
Total.....	.4	.8	2.3	3.5

**III. OLD-AGE, SURVIVORS, AND DISABILITY
INSURANCE BENEFITS**

Old-Age Survivors, and Disability Insurance Benefits

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III. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

As passed by the House, H.R. 1 would have increased social security cash benefits by \$3.9 billion in 1973. More than half of this amount related to a 5-percent across-the-board benefit increase in the House bill.

In the course of the committee's consideration of the House bill, social security amendments were enacted as part of Public Law 92-336. This law provides for a 20-percent across-the-board increase in benefits, effective with respect to checks received by beneficiaries early in October 1972. The new law also provides for automatic increases in social security benefits as the cost of living rises, and provides for an increase both in wages subject to the social security tax (from \$9,000 in 1972 to \$10,800 in 1973, to \$12,000 in 1974, with automatic increases in the limit of wages taxable thereafter) and in the social security tax rates.

In view of this action by the Congress, the committee deleted the 5-percent across-the-board benefit increase in the House bill. However, the committee bill does provide about \$3½ billion in additional social security benefits, over \$1½ billion more than provided in comparable provisions of the House bill. Most of the provisions in the committee bill were approved by the Senate in 1970 as part of the social security bill that passed the Senate in that year, but died when the House refused to go to conference on the bill.

In addition to making more adequate provision for widows and for disabled persons, the committee bill contains several provisions aimed at strengthening the work incentive features of the social security system.

One major feature of the committee bill would provide a special minimum benefit to low-wage workers with longtime attachment to employment covered under social security. A retired worker with at least 30 years of covered employment would be guaranteed a benefit of at least \$200 (if the worker is married the couple would receive a benefit of at least \$300). Another provision of the committee bill would increase retirement benefits for those persons who delay their retirement and thus do not receive benefits after age 65 and before age 72 because of their earnings. The committee bill also increases the earnings limit from the present \$1,680 (\$140 per month) to \$2,400 (\$200 per month).

The individual provisions of the committee bill are described below.

**1. PROVISIONS OF THE HOUSE BILL THAT WERE NOT SUBSTANTIVELY
CHANGED BY THE COMMITTEE**

Increased Widow's and Widower's Insurance Benefits

(Sec. 102 of the bill)

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 the committee's view that the expenses of a widow living alone are no less than those of a single retired worker, and that there is therefore no reason for paying aged widows less than the amount which would be paid to their husbands as retirement benefits. Starting in September 1972, the average benefit for a retired worker will be about \$162 a month, while the average benefit for a widow will be about \$138 a month. In addition, surveys of social security beneficiaries have shown that, on the average, women receiving widow's benefits have less other income than most other beneficiaries.

This provision of the committee bill, like the House 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 who begins receiving benefits when she is 65 years of age or older 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 he began receiving benefits before age 65, an amount equal to the actual benefit he would have been receiving if he were still alive.

Under the committee bill, the benefit for a widow (or widower) who comes on the rolls between the ages of 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 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.

Under the bill, the benefit amount for 3.8 million widows (and widowers) who came on the benefit rolls before the new provisions became effective would be redetermined as though the new provisions had been in effect when they 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 that 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 monthly earnings which determine the pri-

mary insurance amount on which the widow's (or widower's) benefits are based for December 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 \$84.50, the minimum benefit payable under present law to a retired worker at age 65. The benefit for a widow who starts getting benefits before age 62 and who is the only survivor getting benefits would be subject to an actuarial reduction to take account of the longer period over which she will receive benefits.

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

The committee bill makes some technical changes in the House-passed provision which are intended to permit the Social Security Administration to utilize the records now available in computerized form.

Effective date.—January 1973.

Number of people affected and dollar payments.—3.8 million widows and widowers would get increased benefits on the effective date and \$1.1 billion in additional benefits would be paid in 1974.

Age-62 Computation Point for Men

(Sec. 104 of the bill)

Under present law, retirement benefits for men are figured in a way which can result in a man getting a smaller benefit than would be paid to a woman with identical earnings. 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 a woman may disregard 3 more years of low earnings than a man when calculating average wages on which benefits are based, and lower benefits are generally paid to a retired man than are paid to a retired woman with the same earnings record.

For example, take the case of a man and a woman each of whom reaches age 65 and retires in 1972, and each of whom has maximum creditable earnings under the program in each year up to 1972. The woman's benefit would be \$269.70 a month under present law, while the man's benefit would be \$259.40 a month.

The provision would apply only to those who reach age 62 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 1973 would have years up to age 64 taken into account; men who reach age 62 in 1974 would have years up to age 63 taken into account; and men who reach age 62 in 1975 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 the ending point age 62 for both men and women. The bill would thus allow men to become fully insured on the basis of the same amount of covered employment as is now required for women. The first step in

this reduction would be effective for January 1973, with subsequent reductions becoming effective in 1974 and 1975, as with the benefit computation.

With the exception of a few technical changes, the committee amendment is identical to the House-passed provision.

Effective date.—January 1973.

Dollar payments.—About \$14 million in additional benefits would be paid in 1974; the cost of the provision when it becomes fully effective is expected to be about \$400 million.

Reduced Benefits for Widowers at Age 60

(Sec. 107 of the bill)

Under present law, a widow who is not disabled can become entitled to widow's insurance benefits at age 60, but an aged dependent widower cannot become entitled to dependent widower'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 widows. Accordingly, the bill would lower the age of eligibility for dependent widower's benefits from 62 to 60. The benefits payable to a dependent widower who starts getting benefits before age 62 would be actuarially reduced, as are the benefits under present law for widows who come on the benefit rolls before age 62, to reflect the fact that benefits will be received over a longer period of time.

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.

Effective date.—January 1973.

Entitlement to Child's Insurance Benefits Based on Disability Which Began Between Ages 18 and 22

(Sec. 108 of the bill)

Under present law, a person can qualify for childhood disability benefits if he has been continuously disabled—as defined in the law—since before age 18 and is still disabled when his parent dies or becomes entitled to social security benefits. The committee 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. The committee believes that it is consistent with the philosophy of the social security program to provide benefits for these disabled people after the insured parent dies, becomes disabled, or retires.

The committee bill would also permit reentitlement to childhood disability benefits for former childhood disability beneficiaries who again become disabled within 7 years after their benefits terminate.

This change would provide disability insurance protection to a former childhood disability beneficiary until he had an opportunity to work long enough to gain disability protection as a worker. The 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.

Effective date.—January 1973.

Number of people affected and dollar payments.—13,000 additional people would become eligible for benefits on the effective date and \$17 million in additional benefits would be paid in 1974.

Continuation of Child's Benefits Through End of Semester

(Sec. 109 of the bill)

Under present law, the child's benefits paid to a full-time student end with the month in which he reaches age 22. The committee believes that benefits should not be terminated in the middle of a school term. Accordingly, the committee bill includes a provision 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.

Effective date.—January 1973.

Number of people affected and dollar payments.—55,000 beneficiaries would receive additional benefits in the first full year and 6,000 additional people would become eligible for some benefits. About \$19 million in additional benefits would be paid in 1974.

Child's Benefits in Case of Child Entitled on More Than One Wage Record

(Sec. 110 of the bill)

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.

When the present provision was enacted, a child's benefit was always 50 percent of the worker's primary insurance amount, regardless of 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.

As a result of these changes, the amount of a child's benefit based on the earnings record of the worker who has the highest primary insurance amount may be smaller than the benefit based on the earnings record of another worker on whose record he is also entitled.

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 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.

The House-passed bill would provide that a child who is entitled to benefits on the earnings record of more than one worker would be paid benefits based on the earnings record which results in the highest amount, if the payment would not 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.) However, the committee has been informed by the Social Security Administration that the House-passed provision has certain technical deficiencies and the provision has been redrafted to avoid these deficiencies.

Effective date.—Upon enactment.

Adoptions by Old-Age and Disability Insurance Beneficiaries

(Sec. 111 of the bill)

Under present law, a child (other than a natural child or a step-child) 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 this support from the worker for the year before the worker became entitled to benefits, and
- (3) either (a) the child was living with the worker in or before the month in which the worker filed application for old-age benefits or (b) 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.
- Alternatively, if the child was adopted by a worker getting disabil-

ity insurance benefits within 2 years after the worker began to get 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.

The provisions described above are unnecessarily complex and the committee believes 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, the 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.

Effective date.—For benefits for months after December 1967 if an application is filed within 6 months after the month of enactment; otherwise for benefits for January 1973 and later.

Child's Insurance Benefits Not To Be Terminated by Reason of Adoption

(Sec. 112 of the bill)

Under present law, a child's entitlement to 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.

The committee believes that most adoptions are undertaken to obtain 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 when he is adopted. Accordingly, the bill

provides for the continuation of benefits to an entitled child who is adopted, regardless of who adopts him. A child whose entitlement to benefits was terminated because he was adopted and who, except for such adoption, would still be entitled to benefits may, upon filing proper application, become re-entitled to benefits.

Effective date.—Effective upon enactment.

Elimination of the Support Requirements for Divorced Women

(Sec. 114 of the bill)

Benefits, under present law, 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.

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 earn social security protection of their own. The committee believes 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. 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.

Effective date.—January 1973.

Number of people affected and dollar payments.—About 10,000 people would qualify for benefits and about \$23 million in additional benefits would be paid in 1974.

Waiver of Duration of Relationship Requirement for Widow, Widower, or Stepchild in Case of Remarriage to the Same Individual

(Sec. 115 of the bill)

To qualify for survivors' 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 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. The 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, the committee has included in its bill a provision which would waive 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.

Effective date.—January 1973.

Applications for Disability Insurance Benefits Filed After Death of Insured Individual

(Sec. 118 of the bill)

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 benefits 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.

The 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 12 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.

Effective date.—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.

Workmen's Compensation Offset for Disability Insurance Beneficiaries

(Sec. 119 of the bill)

The committee 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 under age 62 qualifies for both workmen's compensation and social security disability benefits, 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 for social security benefits. The purpose 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 the 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 may 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.

Effective date.—January 1973.

Number of people affected and dollar payments.—40,000 people would get increased benefits on the effective date, 2,000 additional people would become entitled to benefits, and \$22 million in additional benefits would be paid in 1974.

Wage Credits for Members of the Uniformed Services

(Sec. 120 of the bill)

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 noncontributory 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.

The committee 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 basic 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.

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.

Effective date.—January 1973.

Number of people affected and dollar payments.—130,000 people would get increased benefits on the effective date and \$46 million in additional benefits would be paid in 1974.

Optional Determination of Self-Employment Earnings

(Sec. 121 of the bill)

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.

The House-passed bill would provide a similar option for all self-employed people. The committee, however, has been informed by the Social Security Administration of certain technical problems which would arise under the language of the House bill. Accordingly, the provision has been redrafted to eliminate these problems. 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) two-thirds of their gross income or (2) \$1,600. 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 by an individual who 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 \$1,600 and less than two-thirds of his gross income—he could not use the optional method to report and pay the 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.

Effective date.—Taxable years beginning after 1972.

Coverage for Vow-of-Poverty Members of Religious Orders

(Sec. 123 of the bill)

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 of the duties required by the order are excluded from coverage under social security. The 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 who were 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 matter pending study by the orders. The provision for extending coverage to members of religious orders which is included in the committee bill takes into account the recommendations which religious orders proposed after completing their study.

The committee 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 taxes on them. The 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. The 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 the election is made.

Self-Employment Income of Certain Individuals Temporarily Living Outside the United States

(Sec. 124 of the bill)

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 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, has in some instances an adverse effect on the social security protection of the worker and his family.

The committee 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 or income-tax purposes) taken by U.S. citizens who have established residence in a foreign country.

Effective date.—Taxable years beginning after 1972.

Coverage of Federal Home Loan Bank Employees

(Sec. 125 of the bill)

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, 1957; 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 the 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 contribution on account of such services are paid by July 1, 1973, or by such later date as may be provided under an agreement entered into between the Banks and the Secretary of the Treasury.

Policemen and Firemen in Idaho

(Sec. 126 of the bill)

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.

In Idaho, and in other States not named in the law, social security coverage is not available to policemen who are in positions covered 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

(Sec. 127 of the bill)

The committee 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 a 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 system prevents the employees in question from obtaining social 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

(Sec. 128 of the bill)

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.

The committee 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 or 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.

Effective date.—For services performed on and after the first day of the calendar quarter which begins on or after the date of enactment.

Coverage Exclusion of Students Employed by Nonprofit Organizations Auxiliary to Schools, Colleges and Universities

(Sec. 129 of the bill)

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. The committee is informed 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.

Therefore, the committee 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.

Effective date.—With respect to services performed after December 1972.

Increase of Amounts in Trust Funds Available To Pay Costs of Rehabilitation Services

(Sec. 131 of the bill)

The committee 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. The committee bill would increase the authorization for use of trust fund money for rehabilitation in two steps—to 1.25 percent for fiscal year 1973, and to 1.5 percent for fiscal year 1974 and subsequent years. The Department of Health, Education, and Welfare has informed the 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.

About \$29 million in additional funds would be available in 1974.

Acceptance of Money Gifts Made Unconditionally to Social Security

(Sec. 132 of the bill)

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 have resulted. The Department of Health, Education, and Welfare 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 legal problems for the survivors.

The committee 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.

Under this amendment, gifts would be credited to the particular trust fund designated by the donor (the old-age and survivors insurance 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.

Payment in Certain Cases of Disability Insurance Benefits With Respect to Certain Periods of Disability

(Sec. 133 of the bill)

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.

The committee has been informed that these people also lost benefits which would otherwise have been paid. Therefore, the committee bill would provide for the payment of cash disability benefits for periods of disability that began after 1959 and ended prior to 1964 that have been established by those persons under the 1967 amendments.

Recomputation of Benefits on Combined Railroad and Social Security Earnings

(Sec. 134 of the bill)

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 benefits based on combined social security and railroad retirement 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.

Effective date.—Upon enactment.

2. PROVISIONS OF THE HOUSE BILL THAT WERE MODIFIED BY THE COMMITTEE

Special Minimum Primary Insurance Amount

(Sec. 101 of the bill)

Under present law, in order to be eligible to receive any social security retirement benefit, an individual must have worked at least a specified amount of time in employment covered under the social security program. Eventually, everyone will need 10 years of employment covered under social security in order to be eligible for retirement benefits; however, a man reaching age 65 in 1960 required only $2\frac{1}{4}$ years of covered employment to be eligible for retirement benefits; one attaining age 65 in 1965 required only $3\frac{1}{2}$ years of covered employment; and a man reaching age 65 in 1971 required only 5 years of covered employment.

Once an individual has sufficient years of covered employment to be eligible for social security benefits, the amount of the benefit for which he is eligible is calculated on the basis of his average earnings in covered employment, including years with no earnings if his employment under the social security program is slight. For example, the benefits for men retiring at age 65 in 1972 generally are based on their 16 years of highest earnings after 1950 under the social security system; a man with 16 years of earnings of \$250 monthly will have the same average monthly earnings as one with 8 years of earnings of \$500 monthly combined with 8 years of no earnings under social security. Thus, the committee feels that it would be appropriate in increasing benefits to distinguish between individuals whose low average earnings result from only slight connection with covered employment and those individuals who worked for years at low wages.

Beginning September 1972, an individual whose average monthly earnings are less than \$76 is eligible for a monthly social security benefit of \$84.50. Typically, an individual has average wages of less than \$76 monthly because for a number of years he was not working in covered employment at all, and these years of no earnings, when averaged in with the years of covered employment, brought his average wages to a low level. This would occur if an individual spent most of his working career in employment not covered under social security but instead covered by another public pension system (such as employment in the Federal civil service, under a State retirement system not linked to social security, or as a policeman or fireman). A woman who spent most of her adult life not working but who had some earnings under social security would ordinarily receive wife's or widow's benefits based on her husband's earnings under social security; however, if he receives another public pension because he never worked under social security, she will probably be receiving the minimum benefit even though his pension benefit may be substantial.

Thus, it appears that many, if not most, people receiving the minimum benefit under social security are doing so because they have had little connection with employment covered under social security.

On the other hand, many people receive relatively low social security benefits because they have worked for years at low wages under the social security system. For example, an individual with average wages of \$200 monthly (whether he worked for 30 years under social security or only for 10 years) receives monthly social security benefits of \$154.40, and a person with average earnings of \$250 monthly (regardless of the number of years worked under social security) is eligible for monthly benefits of \$174.80. These amounts represent the benefits to a single person retiring at age 65; a married couple would receive an additional 50 percent.

The House bill would provide a new special minimum benefit of \$5 times the number of years of coverage a person has under social security. The benefit would be \$85 for a person who had 17 years of coverage, \$100 for a person with 20 years of coverage, \$125 for a person with 25 years of coverage, with a maximum of \$150 for a person with 30 or more years of coverage.

The committee is recommending a special minimum benefit under the program which would provide a payment of \$200 per month (\$300 for a couple) for persons who have been employed in covered employment for at least 30 years. This benefit would be paid as an alternative to the regular benefit in cases where a higher benefit would result.

Specifically, the amendment would provide a special minimum of \$10 per year for each year of coverage in excess of 10 years (there would be no credit for the first 10 years of coverage). Under this provision, the new higher minimum benefit would become payable to people with 19 or more years of coverage; at that point, the special minimum benefit would be more than the regular minimum—\$90 as compared to the regular minimum benefit of \$84.50. A worker with 20 years of coverage under social security would receive a minimum benefit of \$100; one with 25 years would receive a minimum of \$150, while one with 30 years would receive \$200 a month. Minimum payments to a couple would be one and one-half times these amounts.

The minimum benefits under the amendment for persons with various years of covered employment are shown in the following table:

Years of covered employment:	Special minimum benefit
19	\$90
20	100
21	110
22	120
23	130
24	140
25	150
26	160
27	170
28	180
29	190
30 or more	200

These special minimum benefits would not be raised under the automatic benefit increase provisions of the law.

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 \$3,000 base (\$750) in effect before 1951 as an offset to the generous treatment resulting from the use of the presumptive basis.

Effective date.—January 1973.

Number of people affected and dollar payments.—700,000 people would become eligible for additional benefits on the effective date and \$152 million in additional benefits would be paid in 1974.

Delayed Retirement Credit

(Sec. 103 of the bill)

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, because earnings in years after 65 can be substituted for lower earnings in prior years in figuring the average earnings on which benefits are based.

The committee bill would provide increased benefits for people who do not get benefits because they are working between ages 65 and 72.

Beginning with the month of attainment of age 65 and ending with the month before the month in which a worker reaches age 72, 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 1973 with earnings of \$4,000 in each year of his computation period could get a monthly benefit of \$205.80 for each month of 1973. If he worked for 12 months in 1973, earning \$6,000, his average monthly earnings would

be increased from \$333 to \$343, and his benefit before application of the delayed-retirement credit provision would be increased to \$211.20. This amount would then be increased by 1 percent to \$213.40.

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 of the committee bill would require the recomputation of the benefits payable to all retired workers now on the benefit rolls to take account of months (beginning with January 1940) for which benefits were not paid between ages 65 and 72 because of earnings from work. In this respect it differs from the House-passed provision which would only take account of months after 1970 for which benefits were not paid between ages 65 and 72 because of earnings.

Effective date.—January 1973.

Number of people affected and dollar payments.—5 million people would get increased benefits on the effective date and \$198 million in additional benefits would be paid in 1974.

Liberalization and Automatic Adjustment of Earnings Limitation

(Sec. 105 and Sec. 106 of the bill)

Under present law, if a beneficiary under age 72 earns more than \$1,680 in a year, his benefits are reduced by \$1 for each \$2 of earnings between \$1,680 and \$2,880 and by \$1 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 committee bill, beginning in 1973, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed \$2,400 (compared with \$2,000 in the House bill); the bill would also increase from \$140 to \$200 the amount of wages a beneficiary may earn in a given month and still get full benefits for that month. In addition, the committee bill would provide that only \$1 in benefits would be withheld for each \$2 of earnings above \$2,400, regardless of how high the earnings might be.

The committee bill, like the House 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 after age 72. 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 do not affect benefits for the year in which they are 72. However, the law requires that they be included in the individual's earnings for that year, and as a result some people receive—and have to repay—excess benefits because of this misunderstanding.

To eliminate this confusion, the committee 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.)

The provisions in the House bill providing for automatic increases in social security benefits and in the contribution and benefit bases were enacted into law on July 1, 1972, as part of H.R. 15390 (Public Law 92-336).

Under the provisions of the bill reported by the committee, as under the House bill, the retirement test exempt amount—the amount a beneficiary under age 72 can earn in a year and still receive all his benefits—would be automatically increased in proportion to the increase in the level of average covered wages in the first 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 retirement test exempt amount was enacted, or the most recent year in which a determination was made to automatically adjust the exempt amount. The exempt amount would be automatically increased in the same manner as the contribution and benefit base is increased under present law. 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.

Effective date.—The earnings limitation would be increased to \$2,400 beginning January 1973; the first automatic increase could be effective for January 1975.

Number of people affected and dollar payments.—1.2 million beneficiaries would become entitled to higher benefit payments when the earnings limitation is raised to \$2,400, and additional people would become entitled to benefits. About \$1.1 billion in additional benefits would be paid in 1974.

Benefits for Child Based on Earnings of Grandparent

(Sec. 113 of the bill)

The House-passed bill would add a new provision to the law so that the grandchild of a retired, disabled or deceased worker (or of his spouse) can, under certain circumstances, qualify for child's insurance benefits where both of the child's parents are dead. There is no provision now in the law that provides benefits for a child based on the earnings of a person other than his parent or stepparent.

The committee agrees with the House that for some children, the present provisions do not provide sufficient protection. However the House-passed bill does not make provision for children whose parents are severely disabled and who are cared for and supported by a grandparent. The committee bill would modify the House bill to provide benefit payments to these children as well as to those whose parents have died.

The committee bill like the House 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.

The committee believes that while these requirements are appropriate and desirable in most cases, they are too restrictive for grandchildren. The committee bill would modify these requirements as they would apply to grandchildren.

Under the committee 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 were disabled (as defined for purposes of social security disability benefits), 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.

Effective date.—January 1973.

Reduction From 6 to 4 Months of Waiting Period for Disability Benefits

(Sec. 116 of the bill)

The committee bill, like the Senate-passed bill in the 91st Congress, would modify the House-passed bill by reducing the waiting period for disability insurance benefits by two months, rather than 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 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 the committee 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. Reduc-

ing the waiting period from 6 months to 4 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.

Effective date.—January 1973.

Number of people affected and dollar payments.—950,000 beneficiaries would become entitled to higher benefit payments and 8,000 additional people would become entitled to benefits during 1974. About \$274 million in additional benefits would be paid in 1974.

Disability Benefits for Individuals Who Are Blind

(Sec. 117 of the bill)

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, a disabled 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.

The committee recommends—as it did in the 91st Congress—an extension of social security disability protection to additional blind persons by providing that a blind person would be insured for disability benefits with six quarters of coverage earned at any time.

In addition to changing the insured-status requirements, the committee bill would change the definition of disability for the blind to permit them to meet the definition regardless of their capacity to work, and to receive disability benefits regardless of whether they work. Under present law, a blind person must be unable to engage in any substantial gainful activity, or if age 55 or over, unable to engage in substantial gainful activity requiring skills or abilities comparable to those used in any previous work, in order to be considered disabled for benefit purposes.

Under present law, disability benefits are not payable after attainment of age 65, but the beneficiary automatically becomes entitled to old-age benefits. The bill would permit blind persons who have six quarters of coverage to continue to receive disability benefits, rather than retirement benefits, beyond age 65, and because they would be receiving disability benefits rather than retirement benefits, they would not be subject to reduced benefit payments under the retirement test.

The bill would also exclude blind persons from the requirement of present law that disability benefits be suspended for any months during which a beneficiary refuses without good cause to accept vocational rehabilitation services.

Effective date.—January 1973.

Number of people affected and dollar payments.—250,000 additional people would become eligible for benefits on the effective date and \$246 million in additional benefits would be paid in 1974.

Payments to Disabled Former Employee or to Survivor or Estate of Former Employee

(Sec. 122 and Sec. 140 of the bill)

Under present law, social security taxes must be paid on wages paid to an employee after he becomes totally disabled or 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 life insurance salesmen whose renewal commissions have been taxed for many years after their death without increasing the social security benefits. Accordingly, the House-passed 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 committee believes, however, that similar provision should apply to disability insurance beneficiaries and has modified the House bill accordingly by adding such a provision to the bill.

The provision would be effective with regard to any payment made after December 1972.

Issuance of Social Security Numbers and Penalty for Furnishing False Information To Obtain a Number

(Sec. 130 and Sec. 137 of the bill)

Under present law, social security account numbers are issued upon application, often by mail, upon the individual's motion. 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.

Two types of situations have recently been brought to the committee's attention which demonstrate the ease with which additional social security numbers can be obtained and subsequently used for fraudulent purposes. The first situation involved the use of several social security numbers in applying for welfare payments under different names; the second situation concerned the use of social security numbers by aliens entering the United States illegally.

The committee does not believe that Congress should permit the lax system of issuing social security numbers to facilitate evasion of other Federal laws or fraud against federally financed programs. Accordingly, there is a need to take steps to eliminate the issuance of more than one social security number in the future and to provide penalties for the fraudulent obtaining or use of a social security number. It is the committee's belief that more orderly rules for the issuance of num-

bers would make it difficult for an individual to obtain a number, or an additional number, in order to hide his true identity and thus obtain benefits to which he is not entitled or to obtain a job for which he is not eligible.

To deal with this situation, the committee proposes that today's system of issuing social security numbers on a case-by-case basis be replaced by more orderly and systematic rules under which most numbers would be issued through economical group registrations. Specifically, under the committee bill, numbers in the future generally would be issued at the time an individual enters the school system; for most persons, this would be the first grade. In the case of non-citizens entering the country under conditions which would permit them to work, numbers would be issued at the time they enter the country or in the case of a person who may not legally work at the time he is admitted to the United States, at the time his status changes. In addition to these general rules, numbers would be issued to persons who do not have them at the time they apply for benefits under any federally financed program.

After the procedures for issuing social security numbers to school children, aliens, and welfare applicants have been in effect long enough to support the presumption that all persons above school entrance age have been enumerated, the burden of proof would rest on every applicant for a social security number above school entrance age to provide convincing reasons establishing that he had not previously been assigned a social security number. When such individuals established to the satisfaction of the Social Security Administration that they had been assigned no number previously, they would be assigned numbers using the personal data provided by birth certificates or other convincing documents.

Social security numbers are currently used for many purposes beyond the social security system. For example, they must be used by taxpayers in filing their income tax returns and in opening bank accounts or purchasing securities. Similarly, they are used in applying for jobs, credit cards and drivers' licenses. For this reason, the committee's amendment largely relates to the point in time at which a number is issued, and not to whether it is issued to someone who will never need it for social security purposes. Moreover, the committee has been informed that the cost of a group issuance as contemplated by the committee amendment will be substantially less in the long run than issuing numbers on an ad hoc individual basis as is now being done.

As a corollary to this more orderly system of issuing social security account numbers, the committee amendment would provide criminal penalties for an individual who (1) knowingly and willfully uses a social security number that was obtained with false information to obtain benefits under a program financed in whole or in part from Federal funds, or (2) uses someone else's social security number or a number purporting to be a social security number, to conceal his true identity. Under the amendment, the penalty would involve a fine of up to \$1,000 or imprisonment for up to one year or both. The committee changes are designed to perfect and improve upon features of the House bill relating to false information with respect to social security numbers.

Effective date.—On enactment.

3. PROVISIONS ADDED BY THE COMMITTEE

Sister's and Brother's Benefits

(Sec. 138 of the bill)

Under the present law, social security protection is provided for a worker's wife, widow and children and when actual dependency is established, for the worker's aged husband, widower and surviving parent. While these provisions take care of most of the situations in which a person could lose a source of support when a worker retires, becomes disabled or dies, there are some situations in which a sister or brother may be dependent on the worker but can not qualify for social security benefits. These situations are few in number and come about, for example, when a sister remains at home to be a housekeeper for a bachelor or widowed brother or when a severely disabled man or woman is supported by a brother or sister.

The committee believes that in these situations benefits might be appropriately paid to a brother or sister. Thus, the committee bill provides for the payment of monthly benefits to a dependent sister who:

- (a) has attained age 62,
- (b) was receiving at least one-half of her support from her brother at the time he became entitled to benefits, was disabled or died, and
- (c) who files proof of dependency within two years after the time of her brother's retirement, disability, or death.

Payments would also be made to the disabled brother or sister, regardless of age whose disability began before age 22 and who:

- (a) was receiving at least one-half of his, or her, support from a brother or sister at the time he became entitled to benefits, was disabled or died, and
- (b) who files proof of dependency within two years after the time of his brother's retirement, disability, or death.

In the case of a living worker, the benefit payable would be one-half of the worker's disability or retirement benefit. If the worker has died, the benefit to the surviving dependent brother or sister would be 82½ percent of the worker's retirement benefit when only one such person qualifies for a benefit and 75 percent of the retirement benefit when more than one such benefit is payable. (In the case of a deceased worker, the benefit amounts would be determined in the same way that benefits for dependent parents are determined under present law.)

Effective date.—January 1973.

Number of people affected and dollar payments.—50,000 additional people would become eligible for benefits on the effective date and \$79 million in additional benefits would be paid in 1974.

Refund of Social Security Tax to Members of Certain Religious Faiths Opposed to Insurance

(Sec. 139 of the bill)

Since the enactment of the Social Security Amendments of 1965, members of certain religious sects, who have conscientious objections

to social security by reason of their adherence to the established tenets or teachings of the sect, may be exempt from the self-employment tax provided they also waive their eligibility for social security benefits. This exemption is not available, however, for "employees" covered by the social security tax. The exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

As indicated above, the 1965 amendment applies only to members of a religious sect who are self-employed; it does not apply to members of the same sect who work as employees. The report of the Finance Committee in 1965 makes clear that this distinction was intended. It reads in part:

"The proposed exemption would be limited to the self-employment tax under social security since those persons for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment."

In the interval since the 1965 amendment was enacted, an increasing number of members of the Amish sect have become employees. To some extent this is a result of the unavailability of farm land in areas where they reside. In large measure, in the past, the Amish have confined their labors to agricultural pursuits.

In recognition of the changing pattern of employment, the committee concluded that it was appropriate to extend employees the exemptions that are now available only to the self-employed.

Under this provision, an employee who receives wages where the social security tax is deducted may, if the "authorization" under this provision applies, obtain a credit or refund of this tax.

To obtain this treatment, the individual must file an application for the authorization for credit or refund of the social security tax. To qualify for this authorization:

- (1) the individual must belong to a religious sect, which conscientiously objects to the acceptance of benefits under private or public insurance plans;
- (2) it must be the practice of the sect to make provision for dependent families which is reasonable in view of their general standard of living; and
- (3) the sect must have been in existence at all times since December 31, 1950.

Additionally, for the refund or credit to be available the individual involved must be a member of a sect (or a division thereof) referred to above and an adherent of the established tenets or teachings of the sect (or division), and the Secretary of the Treasury may require such evidence of this as he deems necessary.

It should be clear that the allowance of a credit or refund for the employee's portion of the social security tax does not involve any forgiveness of the employer portion of the social security tax.

In order to give effect to this waiver, a provision is added to the Social Security Act (section 202(v)) making it clear that where such a waiver has been filed, no benefit payments are to be made with respect to the wages or self-employment income of such individual and no payments are to be made to him on the basis of the wages or self-employ-

ment income of any other person so long as the individual's authorization remains effective.

Finally, the individual must waive his eligibility for social security and medicare benefits (under titles II and XVIII of the Social Security Act) on the basis of his wages and self-employment income or on the basis of the wages and self-employment income of any other person.

The credit or refund is applicable to wages paid for the first calendar year after 1972 throughout which the individual meets the requirements specified above, and in which an application for authorization is filed (except that if an application is filed on or before the date prescribed by law for filing an income tax return for a year the application may be treated as having been filed in the calendar year in which the taxable year begins). The refund or credit ceases to be available in the first calendar year in which the individual ceases to meet the requirements specified above, or the sect (or division thereof) of which the individual is a member, is found by the Secretary of Health, Education, and Welfare to no longer meet the requirements applicable to it.

Effective date.—January 1973.

Lump Sum Death Payment When Body Is Not Available for Burial

(Sec. 141 of the bill)

In a bill enacted last year (P.L. 92-223) the Congress provided, for deaths occurring after 1970, that the costs of memorial and other expenses connected with the death of an insured individual can be considered as funeral expenses even though the body of the deceased individual (for example a member of the Armed Forces who died in Southeast Asia) is not available for burial or cremation.

Under the provisions of the bill reported by the committee, this provision would be made retroactive to cover deaths occurring after 1960 and would therefore cover the entire period of U.S. involvement in the Southeast Asian conflict.

Effective date.—Upon enactment.

Disposition of Underpayments

(Sec. 142 of the bill)

Under present law, when a beneficiary dies before receiving social security cash benefits due him payment may be made only to a surviving spouse, child, parent, or legal representative of the deceased beneficiary's estate, in that order of priority.

Where there is no surviving spouse, child, or parent and the deceased beneficiary's estate consists of little more than social security benefits due, payment may not be made because some survivors find it too costly to take action necessary to become the legal representative of the estate. When the present order of priority was under consideration in 1967, the committee added a further category under which underpayments could be paid to persons related to the deceased individual

by blood, marriage, or adoption. The Senate change was dropped from the bill by the conference committee. Since then, experience has shown that disposition of underpayments can be made in only about 60 percent of the cases without formal probate proceedings. Where formal probate procedures are necessary, the minimum cost is about \$200, while 90 percent of underpayments amount to less than \$150.

The committee amendment provides that if there is no survivor in the categories listed in present law, any other relative (by blood, marriage, or adoption) of the deceased social security beneficiary may be determined by the Secretary, under regulations, to be the appropriate person to receive, on behalf of the estate, any social security payments due the deceased under title II of the Social Security Act. This provision was contained in the bill reported by the committee in 1970.

Effective date.—On enactment.

Treatment of Income From Sale of Certain Literary or Artistic Items

(Sec. 143 of the bill)

The purpose of the social security earnings test is to provide a practical way of determining whether a person has retired and thus suffered a reduction in income from current work. Accordingly, the law exempts from the test what may be broadly classified as nonwork income such as income from rents, dividends, interest, and pensions. The committee has been informed that an additional class of unearned income—income from the sale of literary and artistic properties created before age 65 but sold after age 65—is currently considered to be earned income. These properties however, are similar to savings or investments in that the income they generate does not result from current work effort. The committee believes that income from their sale should not be counted in determining an individual's income under the earnings test.

The committee therefore added a provision to exclude income from sale of certain literary or artistic items created before age 65 from income for purposes of determining the amount of benefits to be withheld under the social security earnings test. Under existing law, such income is not counted if it is derived from a literary work which was copyrighted before age 65. Under the amendment, the income is not counted for earnings test purposes, regardless of whether or not the work is copyrighted, so long as the work which produced the literary or artistic item was performed before age 65.

Effective date.—January 1973.

Louisiana Registrars

(Sec. 144 of the bill)

The committee has added a provision to the House bill, applicable only to registrars of voters and employees of the registrars, in the State of Louisiana, which would permit the removal of services performed by these workers from social security coverage. About 150 workers are involved.

Under the provision, the registrars and their employees would be given one year in which to decide if they wished to continue their social security coverage and if by December 31, 1973, they decide that they do not wish to do so, and the State notifies the Secretary of Health, Education, and Welfare of its intent to terminate coverage, this coverage would be terminated effective January 1976. Thus, the termination of coverage would not be effective for 2 years in accord with the provision of present law that a State cannot terminate coverage of a group of employees until 2 years after it has advised the Secretary of Health, Education, and Welfare of its intent.

This same provision was contained in the committee bill in 1970.

Social Security Coverage for Foreign Missionaries

(Sec. 145 of the bill)

Under present law, ministers working abroad who have not elected to be exempt from coverage and who are employees of an American employer or serve a predominantly American congregation compute their earnings for social security purposes without regard to the exclusion for social security and income tax purposes of up to \$20,000 of earned income of Americans working abroad. They are therefore covered by social security. Section 130 of H.R. 1 includes amendments which eliminate the \$20,000 exclusion of income earned abroad, for purposes of determining social security coverage, for any U.S. citizen provided he is a resident of the United States during the taxable year.

In order to remove any question as to the social security coverage of U.S. citizens who are priests serving foreign congregations outside the United States and who do not maintain a residence in the United States, the committee added a provision to the House-passed bill removing the requirement that a minister or member of a religious order with earned income abroad must have been either an employee of an American employer or serve a congregation which is composed predominantly of U.S. citizens in order to compute income for social security purposes without regard to the \$20,000 exclusion.

Effective date.—Taxable years beginning after 1972.

Exclusion From State and Local Coverage of Certain Students and Certain Part-Time Employees

(Sec. 146 of the bill)

The committee added a provision to the House bill which would permit a State to modify its social security coverage agreement with the Secretary of Health, Education, and Welfare so as to remove from coverage two types of services—services of students employed by the public school, college, or university which they are attending, and the services of employees of the State or a political subdivision in part-time positions. Under present law, both types of services can be excluded at the time social security coverage is provided for employees of State or local governments, but some States did not elect to exclude the services. There are valid reasons for excluding from coverage employees in these two categories, and some States now wish to exercise

the option they could have made at the time social security coverage was provided for State and local government employees. However, under present law they cannot do so without terminating the coverage of all employees in the affected group. Under the bill, a State could exclude these two types of employment by modifying its coverage agreement with the Secretary of Health, Education, and Welfare before January 1, 1974.

Wage Credits for World War II Internees

(Sec. 147 of the bill)

The committee added to the House-passed bill a new provision designed to protect the rights to social security benefits of certain U.S. citizens of Japanese ancestry who were interned by the U.S. Government during World War II. The credits are intended as a replacement of the wage credit that these internees would have obtained had they not been prevented from working by their internment. Thus, the committee bill would provide noncontributory wage credits for internees who were age 18 and older. The credits will be determined on the basis of the then prevailing minimum wage or the individual's prior earnings, whichever is the larger.

Effective date.—January 1973.

West Virginia Policemen and Firemen

(Sec. 148 of the bill)

The committee has been informed that certain policemen and firemen in West Virginia have been paying social security contributions but that the Social Security Administration ruled (and the courts have agreed) that the law does not provide for this coverage. Under the law, policemen in West Virginia are not allowed coverage if they are also covered under a State or local retirement program and firemen under a State or local retirement program are not allowed coverage unless certain specified conditions are met. The laws of West Virginia require certain local governments to provide a retirement program for their employees, including policemen and firemen, but some of the local governments have not provided the programs and instead have relied on social security coverage to provide retirement, disability, and survivor insurance for their employees. Because this coverage for policemen and firemen, but not for other employees has been determined to be in conflict with the present law, the committee bill includes a provision which will permit the State of West Virginia to modify its social security coverage agreements to provide retroactive coverage for the policemen and firemen who have paid social security contributions in the past and to continue this coverage in the future for those police and fire departments affected.

Termination of Coverage for Policemen and Firemen

(Sec. 149 of the bill)

In a number of instances, policemen and firemen who are covered under social security have subsequently been covered additionally

by a pension plan specifically designed to meet the needs of policemen and firemen. In other instances, where policemen and firemen were covered under both social security and a pension plan, the pension plan has subsequently been greatly liberalized and made more expensive. As a result, some policemen and firemen face a financial burden in attempting to pay both social security contributions and substantial contributions required by their pension plan. If a State terminates social security coverage for such policemen and firemen, the termination must apply to all other employees in the coverage group, ordinarily all the employees of a State or political subdivision, except those engaged in a proprietary function of the State or subdivision. This, of course, often means that other employees who need and want coverage under social security lose protection under the program. In other cases, the termination desired by policemen and firemen is blocked by the opposition to the termination by other employees in the same coverage group.

In view of this, the committee bill adds a new provision which would allow States to terminate coverage for policemen and firemen who are under a retirement system without affecting the coverage of other employees in the same coverage group. Terminations would be subject to the requirements of present law under which States wishing to terminate coverage must give the Secretary of Health, Education, and Welfare 2 years' advance notice; the notice can be given only after coverage of the group involved has been in effect for at least 5 years. The provision would also permit the reinstatement of social security coverage (with no break in continuity) of employees other than policemen and firemen whose coverage had been terminated by prior actions taken to terminate coverage of policemen and firemen, if a majority of the other employees vote to again be covered under social security. The committee believes that providing this special termination provision for policemen and firemen does not provide a precedent for doing the same for other occupational groups, since present law has long included special restrictions designed to prevent policemen and firemen from being brought under social security against their desire, and these provisions have not been extended to other occupational groups.

Compensation of Commissioner of Social Security

(Sec. 520 of the bill)

At the present time the Commissioner of Social Security is at level V of the Executive Schedule (at a salary of \$36,000 per year), as is his deputy. In contrast, other similar positions in the Department of Health, Education, and Welfare are at level IV of the Executive Schedule (at a salary of \$38,000 per year) while their deputies are at level V, one grade lower. The duties of the Commissioner of Social Security—both in terms of the number of employees and responsibilities for supervising expenditures of public funds—are much greater than those of any comparable position in the Department of Health, Education, and Welfare.

In recognition of the high-level responsibilities of the Commissioner of Social Security and to preserve a grade-level separation between him and his deputy, the committee bill in 1970 contained a provision

which was adopted by the Senate that would have placed the position of Commissioner of Social Security at level IV of the Executive Schedule, one grade higher than the grade level of his deputy.

The committee amendment to the House-passed bill again would place the position of Commissioner of Social Security at level IV of the Executive Schedule.

4. PROVISIONS OF THE HOUSE BILL WHICH WERE DELETED BY THE COMMITTEE

During the course of the committee's consideration of the House-passed bill, social security amendments were enacted as part of Public Law 92-336 providing for a 20 percent across-the-board benefit increase effective with respect to checks received by beneficiaries in early October 1972; automatic increases in benefits as the cost of living increases; and a guarantee that no family would have its benefits reduced as a result of any increase in a worker's benefit. In view of this action, the committee has deleted the 5 percent across-the-board benefit increase in the House bill as well as the automatic cost-of-living increase provision and the family guarantee provision.

The committee also deleted three provisions of the House-passed bill which would have little cost impact in the near future, but which over the long run would add significantly to the cost of the social security program; the long-range cost of these three provisions is approximately equal to the long-range cost of a 5 percent across-the-board benefit increase. The committee bill would delete these three provisions outlined below, and instead use the funding to pay for several of the new features in the committee bill already described.

Additional dropout years.—Allows a beneficiary to disregard 1 additional year of low earnings (for purposes of computing average monthly wages on which benefits are based) for each 15 years of coverage.

Actuarially reduced benefits.—Eliminates the provision in present law under which the actuarial reduction made in one benefit (for example, a widow's benefit) lowers the amount of another type of benefit taken later based on another earnings record (for example, a retirement benefit based on one's own earnings).

Combined earnings for couples.—Allows couples married at least 20 years to combine wage credits (up to maximum taxable wages for any one year) for benefit computation purposes.

The first two of these provisions were included in the House-passed bill that was considered by the Senate in 1970 but were not included in the 1970 bill passed by the Senate. The third provision, on the other hand, has not been considered previously by the Senate.

**IV. PROVISIONS RELATING TO MEDICARE-MEDICAID
AND MATERNAL AND CHILD HEALTH**

(171)

Provisions Relating to Medicare-Medicaid and Maternal and Child Health

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IV. PROVISIONS RELATING TO MEDICARE-MEDICAID AND MATERNAL AND CHILD HEALTH

1. PROVISIONS OF THE HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY THE COMMITTEE

Coverage for Disability Beneficiaries Under Medicare

(Sec. 201 of the bill)

The committee has given extensive consideration to proposals 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. It has in past years regretfully concluded that considerations of cost precluded recommending such an extension of coverage. It is now clear that a major unmet need for health insurance protection exists among the disabled. To determine 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, the committee has in recent years directed a number of advisory councils to study this question and to report their findings 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. Use of health services by people who are severely 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 non-disabled 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, the committee bill, as is provided for in the House 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, disabled dependent sisters and brothers, and disabled qualified railroad retirement annuitants.

The committee would also extend medicare protection to women, age 50 or older, entitled to mother's benefits who, for 24 months prior to the first month they would be entitled to medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim. Under the House bill such a woman would have to wait 12 additional months after filing and becoming entitled to disabled widow's benefits before becoming eligible for medicare, because her application would have only 12 months retroactivity. The committee believes that special consideration should be given to these persons who did not file a disability claim earlier because disability determinations are too expensive to be made where no monetary benefit could, under present law, accrue to them. This special consideration would apply for a period of 12 months after the effective date of this provision (until July 1, 1974) in order that all persons who, on the effective date, would have been entitled to disability benefits for 12 to 24 or more months, could avail themselves of medicare protection at the earliest possible time. Those persons who would have been disabled for 12 months or less would, of course, be able to establish their entitlement to disability benefits at a point which would assure them medicare protection as early as possible.

The committee believes, given the cost and financing considerations involved in extending medicare coverage to the disabled, that it is imperative to proceed on a conservative basis. Consequently, the committee bill would provide health insurance protection only after the disabled beneficiary has been entitled to social security disability benefits in one or more of the disability benefit categories mentioned above 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. 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 the committee bill, medicare protection would begin with the later of (a) July 1973, or (b) the 25th consecutive month of the individual's entitlement to social security disability benefits. The House bill provides that medicare entitlement ceases at the same time that eligibility for disability benefits terminates. In a substantial percentage of these cases, disability termination is retroactive; thus, medicare coverage would also terminate retroactively. This would result in expensive administrative adjustments of individual records and would create overpayments for which in most cases, after costly development, the Social Security Administration would have to waive recovery. The committee bill would remedy this situation to the extent of extending medicare protection through the month following the month notice of termination of disability benefits is mailed.

Hospital Insurance Benefits for Uninsured Individuals

(Sec. 202 of the bill)

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 the 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 phase out as of 1974 as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Further, it has become very difficult for many uninsured older people to obtain private hospital insurance comparable to coverage under 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 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.

The committee agrees with but has made some minor changes in the provision in the House bill which would make available hospital insurance coverage on a voluntary basis to persons age 65 and over, 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 through payment of a monthly premium by those who elect to enroll for this protection. During the first year, such premium would be \$33 a month beginning July 1973 and would be recomputed each 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). Aliens who have been in the United States less than five years and persons who have been convicted

of subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee bill also would require that in order for persons to be eligible to enroll for hospital insurance they must also enroll for supplementary medical insurance. Those persons who have failed to enroll for supplementary medical insurance within the 3-year enrollment limit as prescribed by present law would be able, under another provision in the committee's bill to meet this requirement since they would no longer be excluded from enrolling for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Amount of Supplementary Medical Insurance Premium

(Sec. 203 of the bill)

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 93 percent—from \$3 in July 1966 to \$5.80 as of July 1972.

The committee is concerned about the increasingly 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, the committee approves the provision in the House bill which would increase the supplementary medical insurance premium in any given year only if monthly cash social security benefits had been increased in the interval 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 Social Security Act which provides automatic increases in cash benefits under certain circumstances). 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 continue at \$5.80 per month during fiscal 1973. Beginning in December of 1972, 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 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 derivation of the premium amount.

The provision approved by the committee would also authorize the appropriation from 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.

Automatic Enrollment for Supplementary Medical Insurance

(Sec. 206 of the bill)

Under present law an individual eligible for supplementary medical insurance must take the positive action of enrolling to obtain coverage for such 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 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.

Therefore, the committee believes, as does the House, 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. Under the 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 became 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.

The committee has modified the House provision to exclude residents of Puerto Rico and foreign countries from the automatic enrollment provisions since it would usually be to their disadvantage to enroll. Many residents of Puerto Rico are eligible for comprehensive care under its medicaid program, which generally eliminates the need for supplementary medical insurance. Since supplementary medical insurance does not cover services or items furnished outside the United States, beneficiaries living in a foreign country would be protected only to the extent they travel to the United States for treatment.

The 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 disenroll 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 June 1973, because of the practical difficulties that would be involved in locating nonenrollees whose eligibility for medical insurance was established prior to July 1973, and giving them an opportunity to decline the coverage.

Payment Under Medicare to Individuals Covered by Federal Employees Health Benefits Program

(Sec. 210 of the bill)

Under present law, Federal employees and annuitants 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 person'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 are eligible for health insurance protection under a FEHB plan continue to pay the same premium rates for their coverage after retirement (on the basis of age or disability) as they did when they were active employees (although the coverage may be more valuable since older and disabled 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. Under the committee bill the medicare program would be extended to (1) persons entitled to monthly cash benefits under the social security and railroad retirement programs after they had been entitled to disability benefits for at least 2 years and, (2) certain individuals age 60 to 64. It is the committee's intention that, under medicare, the disabled and others under age 65 will be afforded the same basic health care protection as those age 65 and over and that employee health plan policies will be adjusted to complement the protection provided under medicare rather than 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 or to its annuitants 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 allowable under the 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 annuitant 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.

Federal annuitants and employees who are covered under a 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 annuitants and employees do not receive the advantage available to virtually all other persons eligible to enroll in the supplementary medical insurance program, of the 50-percent Government contribution toward the cost of the protection.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and annuitants will eventually have the full value of the protection offered under medicare and FEHB, the committee has approved a provision in the House bill which 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 (1) that there is available to Federal employees or annuitants one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, the protection of Part A alone, 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 annuitants which is at least equal to the contribution it makes for high option coverage under Governmentwide 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 entitled to medicare protection supplementing the combined protection of parts A and B of medicare, the protection of part A alone, and the protection of part B alone, and (2) is making a contribution toward the health insurance of its enrollees entitled to medicare which is at least equal to the contribution made by the Federal Government for high option coverage under Governmentwide 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 annuitant to offset the cost of his purchase of medicare protection, or a combination of the two. The 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 the committee and the Committee on Ways and Means that the Secretary will be able to make this certification for each of the plans under the FEHB program before January 1975. A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Limitation on Federal Participation for Capital Expenditures

(Sec. 221 of the bill)

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 expended 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. The committee and the Committee on Ways and Means believe 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, the 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 planning agencies. It is estimated that 200 areawide planning agencies are receiving grants and that about 125 of such agencies are operational.

To avoid the use of Federal funds to support unwarranted capital expenditures and to support health facility and health services planning activities in the various States, the committee has approved, with a minor change concerning health care facility construction which was already in progress, the House provision which would authorize the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement 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. Where the expenditures are in the form of rental expenses for facilities or equipment which would have been excluded

from reimbursement if they had been acquired by purchase, the Secretary would disallow the "higher" of the actual rental expenses or an amount which he finds to be the reasonable equivalent of the amount which would have been excluded from reimbursement if the facilities or equipment had been purchased. 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. It is generally expected that the agency will be the agency established under section 314(a) of the Public Health Service Act. (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 (on an estimated or proportionate basis without necessarily specific and highly detailed cost-finding of costs with respect to each facility decision undertaken) 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.

It is not intended that any new planning agencies be established where existing State and local agencies are available and capable of assuming necessary responsibility. The statewide agency may make use of local agencies to assist it. Existing local planning agencies should be utilized, however, only to the extent that they are broadly representative of health care interests in the community. The Secretary should assure himself that a local planning agency selected to make such recommendations to the statewide agency is broadly representative of the interests of various types of health care and services and that no single type of facility or service would control the planning and approval mechanism. Additionally, such local agencies should employ or regularly utilize the services of personnel knowledgeable in health care planning. It is expected that decisions to approve capital expenditures would be made only after thorough consideration has been given to alternative health care resources already available in the area or approved in a given community or medical service area, including outpatient and other alternative sources of care which may lead to reduced needs for inpatient beds. The statewide agency with overall responsibility should, wherever possible, be the Comprehensive Health Planning Agency.

These limitations generally would be effective with respect to obligations for capital expenditures incurred after December 31, 1972 or earlier, if requested by the State. However, the committee modified the House bill to, as indicated above, make the provision inapplicable to construction toward which preliminary expenditures of \$100,000 or more had been made in the 3-year period ending December 17, 1970, the date on which the amendment providing a similar exception was offered to H.R. 17550.

Limitations on Coverage of Costs Under Medicare

(Sec. 223 of the bill)

The 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. The 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. The 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 substantially 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 intended that patients who desire unusually expensive service 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 health care services the institution should not be 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. The committee believes that the objectives 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 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.

Accordingly, the committee has approved a provision in the House bill which would authorize the Secretary of Health, Education, and Welfare to set limits on costs recognized as reasonable for certain classes of providers in various service areas. This authority 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 result 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 except with respect to emergency care, provision would be made for a provider to charge the beneficiary for the costs of items or services substantially 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. The 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.

The committee, along with the Committee on Ways and Means, recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And the 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—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 record 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 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.

For other than emergency care, 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 substantially in excess of or 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. The 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 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.

The provision would be effective with respect to accounting periods beginning after December 31, 1972.

Limits on Prevailing Charge Levels

(Sec. 224 of the bill)

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, under medicare regulations 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. Normally, only a relatively small number of situations are affected by additional rules used to judge the reasonableness of charges. In fiscal 1973, however, the increase in allowed charges is to fall under the limitations established by price stabilization policies.

The committee, as well as the Committee on Ways and Means, 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 and follow rather than lead any inflationary trends.

Under the provision approved by the committee, the prevailing charges recognized for a locality could be increased in fiscal year 1974

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.

For purposes of this amendment a "locality" would be defined as an area of a size and nature permitting proper calculation and determination of the types required to adjust prevailing charge levels.

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 1971. 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 expenses 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 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 1972 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 1974 would be 4.2 percent:

$$(.40 \times .03) + (.60 \times .05) = .042$$

The carrier would apply the prevailing charge criteria now in the law to data on charges in calendar year 1972 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1974. 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.

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, the 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.

The committee, along with the Committee on Ways and Means, believes it desirable to embody in the statute the limitations on medical charges recognized as prevailing now set forth in medicare regulations under which no charge may be determined to be reasonable if it exceeds the greater of 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.

The committee believes that it is essential to implementation of the original congressional intent that the Department of Health, Education, and Welfare require that in an area where a significant number of payments are made under Blue Shield and other service benefit and insurance contracts and to the extent such payments are generally accepted by physicians as payment in full, they should be properly reflected in the charge data used in the determination of reasonable charges. Under service benefit plans, for example, the participating physician agrees to accept the Blue Shield allowance as payment in full for services to patients with incomes below specified limits. Where the actual number of cases in which the Blue Shield payment represents payment in full is unknown and valid estimates cannot be obtained, reasonable presumption should be drawn from the number and probable income levels of those covered by service benefit contracts and whether such income levels would generally encompass most beneficiaries and as to the number of instances in which the Blue Shield payment would usually represent the physician's full payment.

While relating the allowability of future increases in prevailing charges to general economic indicators is an appropriate method for reasonable charge determinations with respect to the services of physi-

cians, the 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 lower levels (the comparable House provision referred to "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.

The 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 committee believes that it would be advisable for the Secretary to give priority attention to items of service or equipment most frequently paid for under the program. The committee also believes that there are certain items of service for which special reasonable charge rules can be readily established. Where a separate charge is made by a physician for an injection, for example, the maximum allowance should be a scheduled amount based upon the approximate ingredient and supply cost plus a modest specified amount (such as \$1 or \$2) to cover the injection service. This seems reasonable since an injection generally is not a service requiring a high level of training and experience; paramedical personnel are normally capable of providing and often provide the service. Similarly, schedules of allowances should be established by geographic or medical service area, where appropriate, for routine laboratory work—including interpretation of results—for tests not ordinarily included in the charge for a physician's visit. The scheduled allowance should be based on the costs of tests (including common groupings of tests) when undertaken by qualified, efficient and economical sources—such as independent automated laboratories—to which physicians in an area have reasonable access.

While the provision discussed above, which would be applicable beginning January 1, 1973, is directed to items and services that do not generally vary in quality from one supplier to another, the committee notes that present law provides authority for special reasonable charge rules and limits with respect to any item or service for which such special rules are found to be necessary and appropriate. The committee believes that it is reasonable and desirable to limit charges recognized for routine follow-up visits to institutionalized patients

to a reasonable proportion of charges for the initial visit and to limit charges recognized for visits on the same day to a number of patients in the same institution to amounts that are reasonable in relation to the time usually spent and services provided under such circumstances. Of course, such limitations would not preclude individual consideration of requests for higher allowances where such followup visits or multiple visits are justifiable as being nonroutine.

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 after enactment of the bill may not be made with respect to any amount paid for items and services which exceeds these new limits. This would be consistent with policy 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 have 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 November 11, 1971, HEW issued regulations which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The regulation stipulated that in no case could payment exceed the highest of:

- (1) Beginning July 1, 1971, the 75th percentile of customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made.
- (2) Prevailing charge recognized under part B, title XVIII for similar services in the same locality on December 31, 1970.
- (3) Prevailing reasonable charge recognized under part B, title XVIII.

Under the House bill, the Health Insurance Benefits Advisory Council is directed to study the methods of reimbursement for physicians' services under medicare and to report to the Congress by July 1, 1972, on how these methods affect physicians' fees, the extent to which they increase or decrease the number of cases for which physicians accept assignments, and the share of total physician charges which beneficiaries must pay. It is clear, however, that the group will be unable to complete the study requested by the House by July 1, 1972. The committee has therefore extended the deadline to January 1, 1973 so that HIBAC may comply with the House request.

The proposed amendment is substantially along the lines of the present regulation, and would be effective upon enactment.

Payment for Supervisory Physicians in Teaching Hospitals

(Sec. 227 of the bill)

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 basis. However, the issue of

how medicare should reimburse for the 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 patients 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 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 that were out of all proportion to the covered service or the charges billed to other patients.

In the typical community hospital and other teaching settings where patients are expected to pay fees for these services, fee-for-service payment for physicians' services would continue to be made by the medicare program. 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.

To deal with these problems, H.R. 1 as passed by the House and approved by the committee, contains a provision, originally developed by this committee in 1970, which 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 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. The 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 supervision on a regularly scheduled basis to nonprivate patients. Such services would be 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 medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Medicare payments for such services would be made available on an appropriate legal basis by the fund 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.

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' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup 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 physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. 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.

It is recognized, 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 legally 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.

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. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately for inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organization.

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 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, 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.

The 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.

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.

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.

Another provision in this section would permit a hospital to include among its 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. In order to receive reimbursement the hospital would be required to pay the reasonable cost of such services to medicare patients to the institution that bore the cost. The committee expects that such costs will be reimbursable only where there is a written agreement between the hospital and medical school specifying the types and extent of services to be furnished by the school and disposition of any reimbursement received by the hospital for those services.

This amendment would be effective with respect to accounting periods beginning after December 31, 1972.

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 228 of the bill)

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 posthospital 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.

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for posthospital extended care or home health benefits cannot generally be made until some time after the services have been furnished. The committee is aware that in many cases such benefits are being denied retroactively and that another provision in the committee bill, which would revise the definition of extended care to permit coverage of additional types of skilled care, would not eliminate the probability that such retroactive denials will continue. The harsh result is 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 posthospital 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.

The 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 this purpose the committee has concurred with a provision in the House bill which would authorize 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. The Secretary would undertake such activities to the extent that a Professional Standards Review Organization was not exercising comparable responsibility in an area. 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.

The 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 be limited in duration and will not, in many cases, encompass the entire period for which 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, the Professional Standards Review Organization, which would be established under section 249F of the committee's bill (or the fiscal intermediary where no PSRO is performing such functions) should be able to make appropriate reviews on a timely basis for such admissions.

To prevent abuse of the advance approval procedure the PSRO or intermediary (in the absence of a PSRO) 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 the patients' 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 patients certified by physicians who are found to be unreliable in this respect.

This provision would be effective January 1, 1973.

Authority of Secretary To Terminate Payments to Suppliers of Services

(Sec. 229 of the bill)

Present law does not authorize 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.

The committee believes it important to protect the medicare, medic-aid, 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 medic-aid providers who abuse the program, but they are not now required to do so.

The committee approves the House provision, previously included in H.R. 17550, under which 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 and for whose services payment will not be made. 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). 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. The committee notes that a Professional Standards Review Organization (PSRO), to be established under another provision of the committee bill, would generally have the personnel and expertise to perform this function and, therefore, expects the Secretary to utilize the services of a PSRO whenever feasible in lieu of a separate program review team, as PSRO's become operative.

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

Any person 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.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished on or after December 31, 1972.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Programs

(Sec. 230 of the bill)

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 91-36), 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.

The committee has been concerned with the burden of the medicaid program on State finances. The expansion of the medicaid program and liberalization of eligibility requirements for medical assistance which is required by section 1903(e) could increase this burden and may result in States either cutting back on other programs or their considering dropping medicaid.

The committee agrees with the action of the House repealing section 1903(e). When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in other medical costs inflation, the question of expansion of the program can then be reconsidered.

Amount of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost

(Sec. 233 of the bill)

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 medicaid and the maternal and child health programs) in providing 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.

The 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 maternal and child health programs could not exceed the lesser of the reasonable cost of such services as determined under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, the committee believes that it would be undesirable to apply this provision in the case of services 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 reimbursement for such services. In such cases fair reimbursement for a service could not exceed, but could be less than the amount that would be paid under present law.

The 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, the 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.

The 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, skilled nursing facilities and home health agencies in accounting periods beginning after December 31, 1972. Provisions relating to medicaid and maternal and child health would be effective for accounting periods beginning after December 31, 1972.

Institutional Planning Under Medicare

(Sec. 234 of the bill)

Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, the committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their 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 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."

The Committee on Finance agrees with the provision in the House bill which would require providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals), 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 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.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

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.

Prohibition Against Reassignment of Claims to Benefits

(Sec. 236 of the bill)

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 assignment under the terms of which the reasonable charge is the full 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 Health,

Education, and Welfare 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.

The committee concurs with a provision in the House bill which 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. Also, direct payment could be allowed to a foundation, association, plan, or contractor which provides and administers health care through an organized health care delivery system. An example of this type of organization would be a prepaid group practice or other system recognized by the State title XIX agency. It is not the intent of the committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

This provision 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.

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 effective January 1, 1973, or earlier if the State plan so provides.

Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare

(Sec. 238 of the bill)

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.

The committee approves the provisions in the House bill which 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, the 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.

Use of State Health or Other Appropriate Medical Agency To Perform Certain Functions Under Medicaid and Maternal and Child Health Programs

(Sec. 239 of the bill)

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. The committee believes that this duplication of effort in the verification of and in the establishment and maintenance of health standards is unnecessary and inefficient. The 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.

In its approval of a similar provision in H.R. 17550, the committee authorized the use of the appropriate State agency rather than limiting the designation to "State health agency," since in some States another agency performs the certification function for medicare. The House has incorporated this change into this section in H.R. 1.

The 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. These activities would be undertaken only where they are not duplicative of responsibilities assumed by professional standards review organizations.

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides for the establishment of standards relating to the quality of care furnished

to medicaid recipients, and review by appropriate professional health personnel of the quality and appropriateness of services provided. Federal matching at the 75-percent rate is now available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective January 1, 1973.

Relationship Between Medicaid and Comprehensive Health Care Programs

(Sec. 240 of the bill)

Present law provides that under medicaid all eligible recipients should receive the same scope of services; that those services should be available throughout the State and that recipients should have freedom of choice with regard to where they receive their care.

Section 1902(a) (23) also provides that recipients be allowed to obtain medical care through organizations which provide such services (or arrange for their availability) on a prepayment basis, if the recipient so chooses.

State agencies often cannot make pre-payment arrangements with organizations such as neighborhood health centers or prepaid group practices to provide services to medicaid recipients which might result in more efficient and economical delivery of health services, because the prospective arrangements might violate the law in that some recipients might receive a broader scope of benefits than others. This is so because the possibility for making such arrangements may only exist in certain areas of a State. In addition, 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 provision because the particular contract is a demonstration project, or (b) through establishing a separate premium rate for the particular set of services offered under the State plan.

The committee added an amendment to H.R. 17550 designed to meet this problem by allowing States to waive Federal statewideness and comparability requirements when arranging for the delivery of health services on a prepaid basis. The House has incorporated this provision into H.R. 1.

The committee reaffirms its earlier position in approving the House provision which 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 addition to those offered under 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 expended for medicaid eligibles in the same general geographic area who are not under the proposed arrangement.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(Sec. 242 of the bill)

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 1 year of imprisonment, a fine of \$1,000, or both.

The 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 a provision in the House bill approved by the committee with technical changes, the criminal penalty provision would include such practices as the soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving individuals, providers of health care services and business entities such as corporations, companies, associations, firms, partnerships, societies, and joint stock companies. In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use. The penalty for such acts, as well as false statements or representations 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, the committee believes that a specific penalty for such acts should be provided to deter the making or inducing of such statements. Thus, specific provisions would be included under title XVIII (medicare) and under title XIX (medicaid) of the Social Security Act whereby anyone (including, but not limited to, such business entities as corporations, companies, associations, firms, partnerships, societies, and joint stock companies) 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 recertification 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. A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Coverage of Supplies Related to Colostomies

(Sec. 252 of the bill)

Medicare covers the bag and straps which must be used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often made necessary by surgery for cancer of the bowel). The equipment is covered as it is considered a prosthetic device (a replacement for a body organ).

Some bowel cancer patients have surgery which results in a different type of colostomy necessitating daily irrigation and flushing rather than permanent attachment of a bag. Medicare does not cover this irrigation and flushing equipment, since it is not permanently attached to the body and is therefore not considered a prosthetic device. This results in unequal treatment by the program of patients with colostomies.

The committee bill would add a phrase to the statute to include coverage for material directly related to the care of a colostomy.

The amendment is effective upon enactment.

Coverage Prior to Application for Medicaid

(Sec. 255 of the bill)

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.

The committee agrees with the House that such coverage is reasonable and desirable and recommends, as it did in 1970 in H.R. 17550, that States be required to provide protection for that 3-month period. Therefore, the committee bill requires all States to provide coverage for care and services furnished in or after the third month prior to application to those individuals who were otherwise eligible when the services were received. Included as eligible under the three-months retroactive coverage requirement would be deceased individuals whose fatal condition prevented them from applying for medicaid coverage but who would have been eligible if application had been made.

States are expected to modify their provider agreements where applicable so as to permit the application of appropriate utilization control procedures retroactively in these cases to assure that appropriate and necessary care was delivered.

This provision would be effective July 1, 1973.

Hospital Admissions for Dental Services Under Medicare

(Sec. 256 of the bill)

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.

The committee approves the provision in the House bill which would authorize the dentist who is caring for the patient to make the certification of the necessity for inpatient hospital admission for non-covered dental services under the above circumstances without requiring a corroborating certification by a physician. The 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 either with 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.

Extension of Grace Period for Termination of Supplementary Medical Insurance Coverage Where Failure To Pay Premiums Is Due to Good Cause

(Sec. 257 of the bill)

Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for non-payment 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.

The committee approves the provision in the House bill which 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.

Extension of Time for Filing Claim for Supplementary Medical Insurance Benefits Where Delay Is Due to Administrative Error

(Sec. 258 of the bill)

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 pur-

pose, 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.

The committee has approved a provision in the House bill which 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.

Waiver of Enrollment Period Requirements Where Individual's Rights Were Prejudiced by Administrative Error or Inaction

(Sec. 259 of the bill)

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 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.

The committee shares the belief of the Committee on Ways and Means that where an individual's enrollment rights under supplementary medical insurance has 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 but it is not contemplated that the administration be required to conduct an extensive search for cases which arose prior to enactment.

Elimination of Provisions Preventing Enrollment in Supplementary Medical Insurance Program More Than 3 Years After First Opportunity

(Sec. 260 of the bill)

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 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.

The committee approves the provision in the House bill which would eliminate the 3-year limit with respect to both initial enrollment and reenrollment 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.

Waiver of Recovery of Incorrect Medicare Payments From Survivor Who Is Without Fault

(Sec. 261 of the bill)

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, except that the recovery action may be waived if the individual is without fault and if recovery would de-

feat 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 from any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. In 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 Amendments 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.

The committee approved a provision in the House bill which 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 purposes of title II or would be against equity and good conscience.

Requirement of Minimum Amount of Claim To Establish Entitlement to Hearing Under Supplementary Medical Insurance Program

(Sec. 262 of the bill)

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.

The committee approved a provision of the House bill which 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.

Provide That Services of Optometrists in Furnishing Prosthetic Lenses Not Require a Physician's Order

(Sec. 264 of the bill)

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. The House bill does not provide for any change in the present limitation on coverage of optometric services.

The committee believes 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. The patient's choice of having either an ophthalmologist or an optometrist to furnish him with prosthetic lenses should no longer be biased by this requirement.

The committee therefore agrees with the provision in the House bill which would recognize the ability of an optometrist to attest to 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. (Of course, neither the physician nor the optometrist would be paid by medicare for refractive services when the beneficiary has been given a prescription by a physician for the necessary prosthetic lenses.) This change would not provide for coverage of services performed by optometrists other than those covered under present law, nor would it permit an optometrist to serve as a "physician" on a professional standards review organization.

A similar provision was developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Refund of Excess Premiums Under Medicare

(Sec. 266 of the bill)

Under present law, where part B entitlement terminates due to the death of the enrollee, refund of any excess premiums is made, upon claim, 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.

Early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be 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 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 those provisions of the bill which would provide, at an initial cost of \$33 per month per enrollee, hospital insurance coverage for people who are age 65 and over who are not eligible for such coverage under present law and certain other persons age 60 to 64.

The committee has therefore approved a provision in the House bill which 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.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

Exemption of Christian Science Sanatoriums From Certain Nursing Home Requirements Under Medicaid

(Sec. 268 of the bill)

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.

The committee agrees with the House 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, requirements for medical review, and other inappropriate requirements of the medicaid program.

Such sanatoriums will be expected to continue to meet all applicable safety standards.

The committee approved a similar amendment in 1970.

Increase in Maximum Federal Medicaid Amount for Puerto Rico

(Sec. 271 of the bill)

At present, Federal matching funds for Puerto Rico's medicaid expenditures are at a rate of 50 percent, except that the total amount of Federal funds may not exceed \$20 million in any fiscal year.

The 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 increase in the number of persons eligible for medicaid since 1967, when the ceiling and matching rates were established.

The committee recognizes the efforts made by Puerto Rico to provide comprehensive health care. Among the jurisdictions with medicaid programs, Puerto Rico ranks 13th in expenditures per inhabitant

for medical assistance. Because Puerto Rico spends considerably more on its medicaid program than the \$20 million necessary to receive full Federal matching, the Federal share of Puerto Rico's title XIX program was only about 39 percent in fiscal year 1971.

The committee therefore added a provision to H.R. 17550 providing that the Federal ceiling on title XIX payments to Puerto Rico be increased to \$30 million effective with fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged.

The House indicated their approval of the committee action in 1970 by including a similar provision in H.R. 1.

Inclusion of American Samoa and the Trust Territory of the Pacific Islands Under Title V

(Sec. 272 of the bill)

American Samoa and the Trust Territory of the Pacific Islands are not presently eligible to receive formula fund allocations under the maternal and child health and crippled children programs, as are States and Puerto Rico and the Virgin Islands.

In order to improve maternal and child health and crippled children programs in these areas, the Finance Committee has approved an amendment to authorize eligibility under title V for Samoa and the Trust Territory of the Pacific Islands.

The resulting cost is estimated to be approximately \$35,000 per year.

2. PROVISIONS OF THE HOUSE BILL SUBSTANTIALLY MODIFIED BY THE COMMITTEE

Change in Hospital Insurance Coinsurance for Lifetime Reserve Days Under Medicare

(Sec. 205 of the bill)

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 \$68) and, beginning with the 61st day of his stay, a daily coinsurance amount equal to one-fourth of the inpatient hospital deductible (now \$17). In addition, present law provides each beneficiary with a nonrenewable 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.

The House bill would provide 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 House bill also would provide for an increase from 60 to 120 in the number of "lifetime reserve" days for which inpatient hospital benefits may be paid so that each medicare beneficiary would have avail-

able to him at least 210 days of covered hospitalization, even if he had only one benefit period. As under present law, the beneficiary would be responsible for a coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day used.

The committee bill would delete the provision in the House bill requiring co-insurance payments from the 31st through the 60th day.

While the committee agrees that there is a need to more fully protect medicare beneficiaries against the high costs associated with prolonged use of inpatient hospital services and to promote the most effective utilization of such services, the committee believes that these objectives can best be accomplished with little modification in present lifetime-reserve provisions. The committee bill, therefore, would reduce the coinsurance amount applicable to lifetime reserve days from $\frac{1}{2}$ to $\frac{1}{4}$ of the inpatient hospital deductible. The bill would make no change in the number of lifetime reserve days provided for under present law.

The committee believes that this approach will be of greater assistance to those seriously ill aged who can least afford a high coinsurance amount after having incurred heavy out-of-pocket costs during prolonged hospitalization. Effective professional review is the preferable approach toward preventing unnecessary or avoidable utilization.

The change with respect to the reduced coinsurance for lifetime reserve days would apply to services furnished during spells of illness beginning after December 31, 1972.

Penalty for Failure by States To Undertake Required Institutional Care Review Activities

(Sec. 207 of the bill)

The committee is concerned over the fact that there exists in many areas of the country a substantial degree of unnecessary and avoidable utilization of costly institutional care under medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care. This has been repeatedly demonstrated by investigations of the General Accounting Office, in HEW Audit Agency reports and in other testimony. As a practical matter, the Department of Health, Education, and Welfare has seldom, if ever, recovered from a State amounts improperly spent for non-covered care or services. Additionally, many States have not properly complied with utilization review and independent medical audit requirements of the medicaid program.

While Federal dollars should be used to match State medicaid dollars for the coverage of necessary institutional services under title XIX, those Federal dollars should not be used to pay for unnecessary or inappropriate institutional services.

The Committee on Ways and Means shares this concern. In order to discourage and prevent overutilization, the House bill provided for: (a) 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 TB hospital; (b) 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 institutional care; (c) a decrease in Federal matching by one-third after 90 days of care in a mental hospital (except this period may be extended by an additional 30 days if the State agency certifies that the patient is receiving active treatment and will benefit therapeutically from such additional hospitalization) and provision for no Federal matching after a total of 365 days of such care during an individual's lifetime; and (d) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

Despite general agreement with the objectives of the House bill the committee believes that the approach of the House bill needed improvement because it did not differentiate between those States which are adequately controlling utilization and those which are not, thereby unjustifiably penalizing some States.

The committee has modified the House provision so that, in addition to requiring each State to make a satisfactory showing to the Secretary that it has an effective program of utilization controls over institutional care, it would also require that States, in fact, conduct the independent professional audits of patients as mandated by present law.

The committee believes that a cutoff of Federal matching for hospital and mental hospital care utilizing arbitrary limitations would be inappropriate where the State can demonstrate that the patient needs the care and is benefiting from it. Therefore the committee has amended the House provision so that where a State makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of hospital and mental hospital care, the 60-day limitation in general and TB hospitals and the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals would not apply.

In view of the transfer of the title XI intermediate care facility program to the title XIX program, the committee has brought ICF services into the scope of this amendment. ICF services would be subject to a reduction in Federal matching after 60 days unless the State provides satisfactory assurance that the required review and audits are being undertaken.

To assure actual—rather than paper—compliance with these requirements, the committee amendment would require the Secretary's validation of State utilization controls and independent professional audits to be made on a sample, on-site basis in each State and that such findings be made a matter of public record.

The committee believes that this approach would differentiate between those States which are adequately controlling utilization and those which are failing to meet this objective, and would not unfairly penalize those States which have established proper controls. Thus, only those States which do not employ and apply proper utilization and medical review methods would suffer a decrease in Federal matching.

The committee has eliminated the House provision authorizing an increase in the Federal matching percentage for States contracting with health maintenance organizations or other comprehensive health

care organizations. If health maintenance organizations and other comprehensive health care organizations represent a more efficient and economical approach to the delivery of health services, increased Federal matching should not be necessary as an added incentive for the States to contract with these organizations.

The amendment would be effective July 1, 1973.

Cost-Sharing Under Medicaid

(Sec. 208 of the bill)

Under present law and regulations, States may require payment by the medically indigent (those not eligible for cash assistance because of income and resources) of premiums, deductibles and co-payment amounts with respect to medicaid services provided them, but such amounts must be "reasonably related to the recipient's income and resources." States cannot impose deductibles or co-payments on cash assistance recipients.

The House bill would require States which cover the medically indigent to impose premium charges on the medically indigent. The premium would be graduated by income in accordance with standards prescribed by the Secretary. In addition, under the House bill, States could at their option require payment by the medically indigent of deductibles and copayment amounts which would not have to vary by level of income. Finally, with respect to cash assistance recipients, nominal deductible and copayment requirements, while prohibited for the six mandatory services, would be permitted with respect to optional medicaid services.

The committee substantially modified the above House provisions.

The committee bill, as does the House bill, requires States which cover the medically indigent under their medicaid programs to impose a monthly premium enrollment fee, graduated by income, in accordance with standards prescribed by the Secretary, for those who are not eligible for cash assistance. It is expected that the amount of the premium would not serve as a barrier to entry into the program. For persons entering the program through the so-called spend-down (where medical expenses are deducted from income in determining eligibility), the amount of the premium would be considered as a medical expense. No other premium or enrollment fee could be imposed on the medically indigent under a State's plan, but States may at their option impose non-income related deductibles and co-payments on the medically indigent with respect to patient initiated elective services only. These deductibles and co-payments are expected to be of a nominal nature. The committee does not intend them to apply to inpatient hospital services, skilled nursing home care, or similar services, where the practitioner determines utilization, but only to services where the patient generally initiates use of the service, such as initial office visits to physicians and dentists for routine care. With respect to those services for which the practitioner in the main, determines utilization, the committee expects that the major control of utilization will occur through professional review mechanisms such as PSRO review.

Limiting co-payments and deductibles for the medically indigent to modest amounts for patient-initiated elective services only is consistent with the committee's belief that such cost-sharing devices in the medicaid program should not impose such a financial hardship on the recipient that he is hesitant to seek needed medical services when he is ill. This limitation represents a modification of the House bill, which would allow States to impose non-income related co-payments and deductibles on the medically indigent for all medical services under the medicaid program.

With respect to the indigent required to be under the medicaid program, the committee believes that no premium enrollment fees, deductibles or co-payments should be imposed. The committee believes that the savings which would result from the imposition of co-payments on optional services (\$5 million) would most probably be exceeded by the administrative costs.

Conditions of Medicaid Eligibility for Certain Employed Families and Newly Eligible Adult Recipients

(Sec. 209 of the bill)

Under present law, a portion of the earnings of cash assistance recipients is disregarded in determining the amount of their cash assistance benefit. These "earnings disregard" provisions are intended as an incentive for employment by public assistance recipients. However, the consequent gradual loss of cash assistance as earned income increases can have an unintended work disincentive effect at points in the earnings scale where the earning of an extra dollar can mean the phase-out of cash assistance and the loss of medicaid coverage. Just below this income point, a person might not want to seek greater earnings since additional earnings could make him ineligible for medicaid, with the result that he would lose medical benefits worth many times more than the dollar of marginal income which moved him off the cash assistance rolls. This so-called "medicaid notch" is both inequitable and a disincentive to work.

Even in States which do cover the medically indigent a problem exists, since the maximum eligibility level for the medically needy ($133\frac{1}{3}\%$ of the payment level) is, in a number of States, several thousand dollars below the income level where cash assistance phases out under the earnings disregard provision. Consequently, a family which has worked off of cash assistance and lost medicaid coverage would have to "spend down" to the eligibility level for the medically needy to re-establish their eligibility for medicaid.

The House attempted to remove this "notch" by requiring AFDC families with earnings to pay a medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over \$720 a year. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this

point, however, his medicaid deductible would increase dollar for dollar with his retained earnings.

Although the House provision eliminates any sudden loss of eligibility for medicaid, the provision acts as a substantial work disincentive, since the medicaid deductible increases dollar for dollar, in many cases with retained earnings. In addition, the provision would probably be extremely difficult to administer.

Therefore, the committee has eliminated from the House bill all of section 209, except subsection (d). It has developed in its stead a substitute provision designed to assure that: 1) the medicaid notch is mitigated and no longer operates as a substantial disincentive to work, 2) cash assistance recipients who are now eligible for medicaid will not lose their medicaid eligibility as a result of increased income from employment, and 3) administration of the provision will be equitable and reasonably simple. To accomplish this, the committee has added an amendment which provides that when a welfare family with children loses eligibility for cash assistance because of changes in earnings, medicaid eligibility for that family would be continued for a period of 12 months beginning with the month following the month when cash assistance was terminated, provided that such family had been recipients of cash assistance for at least three of the preceding 6 months.

The committee intends that medicaid benefits are to be available to all families who can meet the cash assistance requirements in the State (regardless of whether such family is receiving welfare cash payments, employment program payments, wage subsidy, or a work bonus). States would continue to provide medicaid coverage for the family for 1 year after their earnings increase to the point where income exceeds the relevant standard. Regular Federal matching available to States under the title XIX program would be provided for such services.

Following the expiration of the 12 months of coverage such families may elect to participate in the medicaid program by paying to the Federal Government (or to the State acting as the Federal agent) a premium equal to 20 percent of the family income in excess of \$2,400 (calculated on a monthly basis). For this purpose, the amount of any work bonus (authorized by title IV of this bill) will not be considered as income. However, all other earned and unearned income, without any disregard, will be considered in establishing the amount of premium liability for the family.

The Federal Government would assume the costs of such families which are otherwise ineligible for medicaid in the State and which opt for medicaid following the end of the 12-month period to the extent that such costs exceed any premiums derived from all such families in a State. If the State has established a premium for the medically needy, in accordance with standards established by the Secretary, as set forth in section 208, that premium would be applied to these families no longer eligible for cash assistance because of increased earnings, during the 12 months of special eligibility for medicaid extended to them under this provision. No other premium could be imposed.

Similarly, employment program families otherwise ineligible for medicaid could opt for such coverage on the 20 percent premium

basis with the Federal Government assuming any additional costs of their coverage.

The medicaid services available to those families not otherwise covered under the State title XIX program and who elect to pay premiums as described above, would include the mandatory services of medicaid, subject to the limitations of duration and scope established by the State in its title XIX State plan, and such other optional services as are provided in that plan for eligible persons under the State program.

The committee has included the substance of the House amendment, which gives States the option of covering under medicaid aged, blind and disabled persons made newly eligible for cash assistance as a result of the increases in payment levels to these persons provided under title III of this bill.

No State would be required to furnish medical assistance to any individual receiving aid as a needy aged, blind or disabled adult unless the State would be (or would have been) required to furnish such assistance to such individual under its medicaid plan that was in effect on January 1, 1972. However, if a State should elect to provide medicaid benefits on the basis of its January 1, 1972 medical assistance standard it would be required to incorporate a spend-down provision comparable to that contained in section 1903(f) so that any eligible individual would be entitled to medicaid only if the income of such individual or family (after deducting incurred medical expenses) was not in excess of the State standard for medical assistance as in effect on January 1, 1972.

For this purpose, the medical assistance standard in effect on January 1, 1972 is considered to be the eligibility standard for cash assistance, or the medical assistance standard for the medically needy program (if the State has established one), whichever is higher.

Payment Under Medicare for Certain Inpatient Hospital and Related Physicians' Services Furnished Outside the United States

(Sec. 211 of the bill)

Under present law, services furnished outside the United States (defined to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) 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 is more accessible than the nearest U.S. hospital that is adequately equipped and available for his treatment.

The House-approved bill provides, with respect to admissions after December 31, 1971, for payment of medicare benefits for inpatient hospital services furnished outside the United States if 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 is 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 patient 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 House-approved bill would retain the provisions of present law with respect to coverage of emergency inpatient hospital services furnished outside the United States.)

Under the bill approved by the House, 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 charges are not made by the hospital, two-thirds of the hospital's total charges.

The House-approved bill also would 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, in order to assure that medicare beneficiaries would be adequately protected against other medically necessary health care costs they may incur while receiving foreign inpatient hospital care.

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 countries, the House-approved 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. This provision was developed by the Committee on Finance in 1970 and included in H.R. 17550 as passed by the Senate.

The committee is fully in agreement with the provisions of the House-approved bill. It has, however, added a new provision to take care of a unique problem faced by U.S. residents who, if they use land transportation to travel between Alaska and the 48 contiguous States, must travel through Canada. The committee amendment would extend coverage to emergency hospital services furnished in Canada to

U.S. residents traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State. The Canadian hospital would have to be closer to, or substantially more accessible from the place where the emergency occurred, than the nearest hospital in the United States which was suitable and available for treatment.

These provisions would apply to services furnished with respect to hospital admissions occurring after December 31, 1972.

Demonstrations and Reports: Prospective Reimbursement; Peer Review; Extended Care; Intermediate Care and Homemaker Services; Ambulatory Surgical Centers; Physicians' Assistants; Performance Incentives

(Sec. 222 of the bill)

Prospective Reimbursement

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.

The committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive or negative financial incentives, to plan, innovate and generally to manage effectively in order to achieve greater financial reward 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, the committee, along with the Committee on Ways and Means, 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, the Committee on Finance agrees with the House bill which 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 the committee that experimentation be conducted with a view to developing and evaluating methods and techniques that might stimulate providers through positive financial incentives to use their facilities and personnel more efficiently, 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 who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under the committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1974, 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.

Although recognizing the promise and potential offered by prospective reimbursement the committee does not wish to preclude experimentation with other forms of reimbursement. The 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 State, 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 ex-

perimental or demonstration project basis, to organizations and institutions 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 the promise of program savings without any loss in the quality of care.

Peer Review

The committee has eliminated the experiments in areawide or community-wide peer review authorized by the House provision as these experiments would be unnecessary in view of its approval of the Professional Standards Review Amendment.

Extended Care

The committee is concerned about the difficulties facing some beneficiaries who need extended care 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 undertaking, the committee expects him to conduct studies and engage in experiments to determine the effects of eliminating or reducing the three-day prior hospitalization requirement, which he has authority to waive for the purpose of such experimentation, and report to the committee his findings together with any recommendations he may have for changes in this provision of existing law.

Intermediate Care and Homemaker Services

The bill would also authorize experimentation with the use of institutional and homemaker services as alternatives to more costly post-hospital benefits presently provided under title XVIII. This authority would be designed to determine the most suitable level of care for medicare beneficiaries who are ready for discharge from a hospital, or who are unable to maintain themselves at home without assistance. Experiments and projects could include (1) making payment for each day of care provided in an intermediate care facility count as one covered day of care provided in a skilled nursing facility, if that care was for the condition for which the person was hospitalized, (2) following hospitalization covering the services of homemakers for up to 3 weeks, where institutional services are not needed, (3) determining whether such coverage would effectively lower long-range costs by postponing or precluding the need for higher-cost institutional care or by shortening such care, and (4) ascertaining what eligibility rules may be appropriate and the resultant costs of application of various eligibility requirements, if the project suggests extension of coverage would be desirable. These experiments and projects would be conducted only in areas where there is effective professional control precluding inappropriate utilization, as determined by the Secretary.

Ambulatory Surgical Centers

Recently, a new type of health care facility—the ambulatory surgical center—has come into existence. This type of facility functions independently of a hospital and is primarily engaged in performing on an outpatient basis surgical procedures which usually involve the use of general anesthesia.

Under the medicare law, reimbursement for services provided in ambulatory surgical centers is limited to the reasonable charges for physicians' services. No reimbursement is made for costs attached to the facility itself—that is, cost of the operating room, the recovery room, or other space provided. The committee believes that such facilities may meet a useful need, in economical fashion, in the health care delivery system. However, the committee believes that it is advisable to defer consideration of this type of facility as a provider of services under medicare until the concept of an ambulatory surgical center can be further evaluated. At present there is a lack of agreement among professional people as to the feasibility and desirability of these centers.

The committee added to the House bill a provision which would authorize the Secretary to conduct a study of the various types of facilities (such as the Surgicenter in Phoenix, Arizona) engaged in providing surgical or other services to ambulatory patients. If, as a result of this study, the Secretary finds that coverage of presently non-covered services provided by one or more types of ambulatory surgical or health care centers offer promise of improved care or more efficient delivery of care and would not result in cost to the program in excess of what would otherwise be incurred for such services, he would be authorized to enter into an arrangement with one or more of such facilities to conduct a demonstration project to determine the best method of reimbursing such facilities under medicare.

Physicians' Assistants

Under present law, part B of medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physician's office by para-medical personnel. For example, if a nurse administers an injection in the office, medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, medicare will not recognize a physician's charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home.

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring necessary care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 100 experimental training programs for physician assistants and nurse practitioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the

Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while medicare does not, in some instances, recognize all their services as reimbursable items.

Others argue that medicare does reimburse physicians for services provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They contend that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for medicare to take the lead in encouraging doctors—by generous reimbursement—to use physicians' assistants to work independently or to expand their responsibilities.

The committee has included a provision authorizing demonstration projects to determine the most appropriate equitable methods of compensating for the services of physicians' assistants. The objectives are development of non-inflationary alternatives which, if accepted for general use, would not impede the continuing efforts to expand the supply of qualified physicians' assistants.

Reimbursement under these demonstration projects would not be made to physicians for services performed by physicians' assistants unless such services are of kinds performed independent of the employing physician's immediate supervision and unless such assistants are clearly trained and legally authorized to specifically perform those independent services.

In addition it would seem inappropriate to reimburse a physician his regular fee-for-service rate if the service was performed wholly by the physician's assistant. This would merely serve to vastly increase and inflate medical care costs in large part by increasing physicians' incomes.

Medicare would be given demonstration authority to study, develop, and make such types of reimbursement on a demonstration basis as might serve to provide bases for equitable, economical and non-inflationary compensation for the independently rendered services of physicians' assistants.

Carrier Performance Incentive Contracts

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 carriers and intermediaries.

Financing

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 for projects for services delivered to medicare patients.

Demonstration projects for prospective reimbursement for services delivered to medicaid and title V recipients would be financed with funds appropriated under titles XIX and V of the Social Security Act. To the extent that joint projects are funded, involving medicare beneficiaries as well as medicaid and title V recipients, the cost would

be appropriately divided between the trust funds and the other two titles.

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance, for their information, plans for each experiment or project authorized under these provisions, including a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study—rather than approval—before the experiment or project is put into operation.

Payments to Health Maintenance Organizations

(Sec. 226 of the bill)

Introduction

Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single capitation payment such as the organizations normally charge for services covered under both the hospital insurance and supplementary medical insurance parts of the medicare program. Instead medicare reimbursement to group practice prepayment plans may not exceed the costs to the organization of providing specific services to beneficiaries, so that any of the financial incentives which such organizations may have in their regular nonmedicare business to keep costs low and to control utilization of services are not fully incorporated directly in their relationship with medicare.

Of course, the committee believes that a proper sense of professional responsibility also should obtain in patient care and should be of greater significance than economic incentives in assuring appropriate utilization of health care services.

Nonetheless, a disincentive to control of costs and utilization of services occurs to an extent in the present, usual approach to payment for services in the health field where payment is made to the provider for each individual service performed, so that other things being equal, there is an inherent economic incentive to provide services which may not be essential, and may even be unnecessary.

Because the comprehensive care organization receives a fixed annual payment from enrollees, regardless of the volume of services rendered, there is a financial incentive to the organization, by its administrative supervision and review, to control costs and to provide only the least expensive service appropriate to the enrollee's needs. The incentive to the organization may be passed on to the doctor by paying him on a salary basis or providing a bonus or similar profit-sharing arrangement when costs are kept low. On the other hand, there is also present in such systems an economic incentive to provide less care than is necessary so as to reduce costs and further maximize financial gain; thus, a strong need exists to provide effective assurances of proper care.

The committee believes it is desirable for medicare to relate itself to prepayment health care organizations in a way which conforms on a closer basis to their usual way of doing business, and agrees with the concept, embodied in the House bill, of making a health maintenance organization (HMO) option available to medicare beneficiaries.

The HMO amendment to the Social Security Act does not purport to serve as the definitive legislation or otherwise limit organizations

which might be termed HMO's for purposes of organized delivery of health care. Such organizations may assume a variety of guises and play a varying range of roles. The purpose of this amendment is solely to establish a mechanism for determining *which* HMOs are acceptable for incentive reimbursement under medicare. It is an amendment intended to protect beneficiaries and public trust funds—in fulfillment of the committee's responsibilities.

The committee's study of the House provision reveals a number of serious problems with respect to HMO's which should be remedied. Consequently the committee has made several modifications in the HMO provision designed to reasonably safeguard the interests of the public programs and beneficiaries while, at the same time, encouraging the development and recognition of qualified HMO's. The major modifications fall into two general areas—reimbursement of HMO's and assurance of quality of care.

Under the House provision, medicare payment to a health maintenance organization with respect to beneficiaries enrolled with it would be made on a prospective per capita basis, encompassing all medicare-covered services, determined annually in accordance with regulations of the Secretary, at a rate equal to 95 percent of the estimated amount that would be payable if such covered services were furnished outside of the framework of a health maintenance organization. Within this payment, the rate of retention (gross revenue less costs) on medicare enrollees would not be permitted to exceed the rate on other enrollees of the health maintenance organization. The Secretary would examine the relative rate of retention, as determined by generally accepted accounting principles, after each accounting period and any excess retention realized on behalf of medicare beneficiaries must be applied toward additional benefits or reductions in premiums charged to medicare enrollees or refunded to the trust funds.

The committee has several basic reservations about the House provision for HMO reimbursement. First, it is clear that the actuarial adjustment process used to determine the amount payable to the HMO will not be of sufficient precision for the purpose—certainly during the first several years. Factors such as enrolling the disabled and covering the cost of maintenance drugs would involve estimates with which experience is very limited. If an HMO were to enroll relatively good risks (i.e., the healthier medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustment—could result in large “wind-falls” for the HMO as the costs of caring for these beneficiaries might turn out to be much less than medicare's average per capita costs. A similar windfall might accrue if the HMO were to offer poorer than average service or less qualified physicians than those generally utilized in an area. Errors of estimate might also go against the HMO, even though the HMO's would strongly resist accepting a level of reimbursement which involved a high risk of loss. Furthermore, changing enrollment or conditions of enrollment could have significant cost effects on all but the largest HMO's.

Once a valid reimbursement rate is determined, a second issue remains as to the extent to which the HMO and the Government should share in any savings achieved by the HMO.

Reimbursement

To more adequately respond to the full range of legitimate reimbursement needs of HMO's, the committee bill would provide for two methods of reimbursement, each designed for a particular type of organization. One method of reimbursement, available to HMO's which have reasonably demonstrated a capacity to provide health care of acceptable quality in an organized and effective manner, would relate the ultimate payment directly to the actual costs of a similar beneficiary population outside the HMO, providing a formula-incentive payment when the HMO achieves savings compared with average costs of health care delivery. The other reimbursement provision is designed primarily for newly established HMO's whose operating experience and medicare population are not sufficient to provide a satisfactory base for actuarial rate determination or to assure ability to deliver health care services effectively and economically. Start-up costs would normally have the effect that no savings over outside costs could be achieved soon after the development of an HMO. Therefore, this reimbursement provision was designed to give such organizations experience with the capitation payment mechanism but would tie the ultimate medicare payment directly to actual costs incurred by the HMO for the types of expense allowable under medicare on behalf of its medicare enrollees.

Under the reimbursement provisions developed by the committee, the Secretary would be authorized to contract on a prepaid per capita basis for medicare services with substantial, established HMO's: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined part A-part B capitation rate. Such reimbursement would be authorized for HMO's which: (1) have been providing for at least 2 years, a comprehensive range of services similar to those required to be provided to medicare enrollees under this provision and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over.

The Secretary would be authorized to make exceptions to the minimum enrollment requirement only in the case of HMO's in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation, capacity to provide health care services of proper quality on a prepaid basis (even though they may not have actually provided such care on this basis to any large number of people for an extended period) but which have at least 5,000 members. This would enable organizations with proved ability to be eligible for participation as an HMO. An HMO could be considered to serve a sparsely populated area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its service area, or if it is located outside of a metropolitan area and its facilities are reasonably accessible to less than 50,000 people.

HMO's with fewer than 25,000 enrollees would present special problems because of the difficulty of determining a valid rate on a relatively

small population base, and because such organizations will have less in-house capacity to provide medical specialty services. Accordingly, exceptions to the 25,000 minimum enrollment principle in rural or sparsely populated areas should be contingent on a finding by the Secretary that the HMO (1) has established effective referral mechanisms to assure that its enrollees have the benefit of appropriate specialty services so that they are not disadvantaged with respect to quality of care as compared with other residents of the same geographical area, and (2) has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a valid reimbursement rate. Reimbursement to the HMO would be related to the costs of services for the types of expenses allowable under medicare for a non-member population that receives services normal for the specific area or similar areas.

Reimbursement: Established HMO's

An organization which qualifies as an "established" HMO would be eligible to contract with the Secretary for reimbursement on an incentive basis. Under this provision, the HMO would submit, at least 90 days prior to the beginning of a prospective medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding medicare costs in its area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate, which would be payable monthly, in advance, would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost." If the HMO failed to submit the required cost data on a timely basis, the Secretary could reduce the interim payments as appropriate until the necessary information was submitted and an equitable interim reimbursement rate determined.

The initial cost estimates would be updated by the HMO (using reasonable estimating procedures satisfactory to the Secretary) on a quarterly basis, during the contract year to reflect any substantial changes in actual costs compared with the estimates. Interim payments to the HMO would be adjusted as indicated in such reports, subject also to the estimated adjusted average per capita cost ceiling.

At the end of the fiscal year the HMO would submit independently certified financial statements, including certified cost statements allocating allowable types of operating costs (on an incurred basis) to the medicare population. Allocations may use utilization data, statistics, and methods of analysis acceptable to the Secretary in lieu of allocations based upon charges in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance, generally, with medicare accounting principles. All HMO's would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General and the Inspector General for Health Care Administration.

The Secretary would retroactively determine, on an actuarial basis, the "adjusted average per capita cost" incurred for the fiscal year; that is, what the average per capita costs for part A and part B services

would have been if the HMO's medicare beneficiaries had been served through other health care arrangements including other HMO's in the same general area. Where the area was significantly underserved and the HMO provided adequate service, costs of adequate service in other areas would be taken into account.

The committee recognizes that, in the early stages of administration of the HMO provisions, the number of individual actuarial adjustment factors which can be effectively applied in making such calculations will be more limited than will be the case subsequently. At a minimum, however, the actuarial determination would include, in addition to adjustment for geographic variations, adjustments (determined and applied separately for part A and part B services) for age and sex distribution and institutional and disability status of the enrolled beneficiary population. Social security data could be used to obtain information on these characteristics. As additional experience is acquired, adjustments should also take into account other factors such as the extent of use of specialists as compared to general use of specialists in the area and, the extent of the use of interns or residents. Also, in the initial stages of implementation, the definition of "area" used in calculating non-HMO costs may not adequately take account of the particular circumstances of individual HMO's. For example, if "area" were defined as the county or counties included in its service area, an HMO providing services in a high-density, high-cost location might be unduly penalized because the county in which it was located was largely rural and low-cost. It is expected that as the actuarial methodology is refined, the definition of area will be modified so as to prevent an HMO from being either penalized or rewarded by anomalies.

If the HMO's incurred costs are less than the adjusted average per capita cost, the difference, called "savings," would be divided between the Government and the HMO in accordance with a prescribed formula. Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80-percent level would be allocated entirely to the Government. Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would receive a bonus equal to 7½ percent of the adjusted average per capita costs. Of course the 7½ percent of outside costs would represent a bonus of almost 10 percent in terms of the HMO's costs.

At the option of the HMO, it could apply any amount of its bonus toward improved benefits, reduced supplemental premium rates, other advantages for beneficiaries, or retain the money. It could not, however, make cash refunds to beneficiaries.

If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would also be allocated. The amount of excess costs between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 25 percent by the HMO and 75 percent by the Government. Costs in excess of 120 percent would be

borne entirely by the Government. Any losses incurred would carry forward and be recovered from future favorable experience. Thus, any losses by the Government would be recovered in full before any bonus could be paid to an HMO in future years.

In aggregate effect, this committee provision for reimbursing HMO's differs from the House version in two basic respects. First the House version provides that comparative economies achieved by the HMO will be allocated to one or more of three groups—the beneficiary, the HMO and the Government—whereas the committee version would mandate a two-way sharing of savings between the HMO and the Government. The committee believes that the HMO itself would be in the best position to decide whether to allocate part of its bonus to the beneficiary. One organization might decide to use its incentive bonus to offer additional benefits to medicare enrollees, another to attract personnel, or expand facilities. In this regard, the committee is also concerned with the real possibility that, under the House version, beneficiaries might get additional benefits following receipt of incentive payments for a “good” year and would count on them only to have them taken away in the next “bad” year.

While the committee believes it is not improper for medicare to offer the possibility of profit to a health care deliverer if there is reasonable expectation that this approach will benefit the program generally, it does not believe that medicare should, by statute, favor one group of beneficiaries over another. Mandating increased benefits in an HMO as the House bill would have done could have that effect, since it would result in some of those beneficiaries who have had an opportunity to enroll in certain HMO's being mandated advantages in the form of extra benefits over persons who did not choose or have an opportunity to enroll in such an HMO even though they may have used service arrangements—including efficient fee-for-service practitioners and providers—with as low or lower costs than some of the HMO's.

The second basic difference between the House version and the committee provision for incentive-based reimbursement lies in the allocation of differences between the HMO's costs and costs of other beneficiaries. On this point, the committee believed that the provision should be more equitable to the HMO and Government throughout the full range of possible outcomes and should not provide as potentially significant an incentive to underservicing or inadequate service as does the House version. The committee approach calls for sharing of both savings and losses in an individual contract year, with provision for recouping any prior “loss” amount from future savings. By contrast, the House provision places the entire loss burden (plus the 5 percent difference between full outside per capita costs and the 95 percent payment rate) directly on the HMO with no provision for subsequent recoupment of prior losses. This places a significant risk of insolvency or inability to provide contracted-for services during a “bad” year on the HMO with limited financial reserves. The following table shows the difference in gain (or loss) earned, House and committee versions, assuming the gain in nonmedicare business equals or exceeds the profit on medicare:

COMPARISON OF GAINS (OR LOSSES) TO AN HMO UNDER THE HOUSE AND FINANCE COMMITTEE VERSIONS AT SELECTED LEVELS OF COST

If an HMO's cost as a percent of outside costs is—	Under the House version		Under the Finance Committee version	
	The HMO's gain (or loss) as a percent ¹ of outside costs will be—	The HMO's gain (or loss) as a percent ¹ of its own costs will be—	The HMO's gain (or loss) as a percent ¹ of outside costs will be—	The HMO's gain (or loss) as a percent ¹ of its own costs will be—
120.....	(25)	(21)	(8)	(7)
110.....	(15)	(14)	(5)	(5)
105.....	(10)	(10)	(3)	(2)
100.....	(5)	(5)	---	---
97.....	(2)	(2)	2	2
95.....	---	---	3	3
92.....	3	3	4	4
90.....	5	6	5	6
88.....	7	8	6	6
85.....	10	12	6	7
80.....	15	19	8	9
50.....	45	90	8	15

¹ Rounded to the next full percent.

As the table shows, the committee version is more favorable than the provision in the House bill when HMO costs are more than 90 percent of outside costs. The House version may offer large incentives—as much as a 90 percent excess payment above HMO cost—if services to the aged (and nonmedicare members) are greatly reduced.¹ The committee approach is based on the belief that such a reduction is likely to be detrimental to the aged. Research in costs of health care for the aged shows no such potential saving if adequate services are provided when needed.

It is intended that the medicare program make every effort to achieve prompt final settlements with HMO's at the end of their fiscal years. However, program experience indicates that processing of detailed cost reports and the inevitable time lag between the close of a fiscal year and the availability of data on non-HMO costs could produce substantial delays in final settlement. Therefore, the committee has included a provision which would assure that the efficient HMO realizes full value of its share in program savings (even though incentive bonuses would be paid only at the close of the year); that HMOs suffer no financial disadvantage through delayed settlement when an additional sum is payable at year's end; and that the Government suffers no loss when repayment of an overpayment is delayed.

The committee expects that, within 90 days following close of the accounting period, an interim settlement would be reached on the basis of the best available data; 50 percent of any estimated residual amount due the HMO or Government under the sharing formula would be paid at that time. For purposes of the interim settlement, the HMO's per capita incurred costs during the course of the year (or, if feasible, a reestimate at the end of the year) would be compared with the updated estimated adjusted average per capita incurred cost outside the HMO, which serves as the ceiling in determining capitation payments, to make a tentative determination of payment or repayment due. Final

¹ It should be noted that the gain under the House version may actually not be as large as indicated because it could not exceed the retention in nonmedicare business.

settlement, including payment of additional savings or underpayment of cost due the HMO, as well as overpayments recoverable by the Government, would take place as soon as feasible following accumulation of sufficient data necessary to assure reasonably precise actuarial determinations of per capita expenses within and outside the HMO. Any amount due at the time of final settlement would be paid with interest accruing from the 91st day following the close of the year and would be payable at the average rate of interest payable on obligations of the Federal Government if issued on the 91st day for purchase by the medicare trust funds. Thus, the HMO would not suffer financial penalty from delays in final settlement before full payment is made of savings, nor would the Government gain by such delay.

Reimbursement: New HMO's

The committee believes that, in general, HMO's with less than 2 years' operating experience are not apt to have a medicare population sufficient to provide a satisfactory basis for evaluating their actual ability to deliver health care services in satisfactory fashion to beneficiaries and for actuarially sound rate determination. Nor will their operating experience be sufficient to provide a proper basis actuarially for estimating financial requirements for a year in advance. Thus, a per capita reimbursement rate would be difficult to develop and administer, and would involve uncertainty.

However, it seems appropriate to permit a new HMO, at its request, to function under "costs only" per capita rate system of payment so that the organization can become accustomed to planning and functioning on the basis of a predetermined budget rather than in traditional fee-for-service terms. Accordingly under the committee bill, an alternative reimbursement provision authorizes the Secretary to contract with developing HMO's for an interim periodic payment method of reimbursement to cover both part A and B services (provided the HMO undertakes responsibility for providing or arranging for such services). This payment would be interim only and would be subject to adjustment at the end of the contract period to reflect the HMO's expenses otherwise reimbursable under title XVIII of providing covered services to its medicare enrollees.

Under this option, developing HMO's would neither have an opportunity to profit nor be at risk. At the same time, HMO's in the developing category might, of course, be eligible for grant, loan, and loan guarantee assistance.

After at least two years of providing comprehensive services and when its enrollment reaches a minimum of 25,000, such HMO's would become eligible to apply for reimbursement as established HMO's. The same would be true after 3 years of operation in the case of HMO's in smaller communities and sparsely populated areas with 5,000 enrollees under the exception provisions previously discussed. The 2 or 3 year operating period would not be deemed to commence until the organization was, in fact, serving a sufficient number of enrollees to provide an adequate basis for accurately projecting per capita costs. Ordinarily such period would begin with the time when it has enrolled about one-third of the minimum enrollment requirements.

The Secretary would issue regulations defining the conditions a developing HMO would have to meet in order to qualify as potentially eligible for reimbursement on an incentive basis. It is contemplated that the developing HMO would not have to completely meet the standards required for participation as an established HMO. For example, it would not be required to provide as comprehensive a benefit package as the established HMO, nor would it be required to operate primarily on a prepayment basis, although it would need to be providing services to an enrolled population or have some other method acceptable to the Secretary of providing a sound base for making proper cost projections.

Since the developing HMO could not be assumed to provide all the services or meet the standards of established HMO's, if beneficiaries enrolled in developing HMO's obtained services covered under medicare from sources other than the HMO, these outside services would be paid for by the medicare program if not covered by the HMO; that is, the enrollees would not be "locked-in" to the developing HMO. The developing HMO, as previously noted, would not be eligible for incentive payments until fully qualified. It is expected, of course, that the various elements of a developing HMO, such as a hospital, skilled care facility, or clinical laboratory, would, like the elements of a risk-sharing HMO, have to meet the conditions of participation or other quality standards which apply to such organizations under present law. It is also expected that the Secretary's regulations would be designed to assure that only organizations which offer a reasonable prospect of eventually fully meeting the statutory definition of an HMO would be permitted to participate for purposes of medicare as a developing HMO.

To provide needed flexibility, the committee provision would also permit new HMO's which are divisions or subsidiaries of an established HMO and for which an established HMO is willing to assume responsibility for financial risk and assurance of adequate management and supervision of health care services to be treated the same as an established HMO and would not be required to demonstrate actual experience as independent units. In addition, two or more independent HMO's would be permitted to combine through merger or effective affiliation arrangements in order to satisfy the minimum enrollment standard. As in the case of the limited exception to the minimum size requirement previously discussed, the Secretary would be expected to exercise careful judgment to assure that the relationships between established and new HMO's or between two or more smaller HMO's which wish to combine to meet the 25,000 member standard are effective and viable, rather than pro forma.

Reimbursement: General

Under the reimbursement provisions of the committee bill, the per capita cost determinations will, as under the House provision, recognize as allowable reasonable costs only those types and items of expense allowed under medicare generally.

The committee expects that a return on equity capital would be payable to proprietary ECF's and hospitals owned by an HMO under the same regulations applicable to such facilities under the principles

of reimbursement for provider costs under the regular medicare program. The committee would emphasize that reimbursement to HMO's would, as is all reimbursement under title XVIII, be subject to standards of reasonableness, and the Secretary would be expected to assure, by means of postpayment audits on a sample basis or by other appropriate procedures, that the allowable costs incurred by HMO's in providing and arranging for services for medicare beneficiaries are not excessive. The Secretary would, of course, be expected to establish regulatory guidelines as to the reasonableness of incurred costs in certain areas where there is a substantial possibility of abuse, as he does under existing law. An example of a cost item where the Secretary would be expected to establish reasonable limits would be the amount of net profit allowed in the reimbursement of physician partnerships (or other forms of medical group practice) and compensation of the physicians involved which the HMO would be allowed to include as a cost under medicare.

Another potentially troublesome area might be costs incurred by organizations related to the HMO. To avoid excessive payments in the case of related organizations (those with overlapping financial interests, either direct or indirect) the committee provision requires that all HMO financial statements called for be submitted on a consolidated basis, disclosing costs, and charges if different, pertaining to medicare services furnished by the related organizations. In addition, the Secretary could recover or adjust amounts found on the basis of comparative data to constitute excess payment (using in general, medicare limitations on such payments) to related organizations, owners, controllers or sponsors of the HMO.

An HMO which arranges for part A institutional (hospital and skilled nursing facility) services would be free to negotiate payment rates, subject to certain limitations. If the institution is an affiliated unit, the consolidation provisions, and restrictions on payments to related organizations and excessive compensation would apply. If the HMO maintains that it should compensate an institution at a level greater than the regular medicare level of payment (or equivalent) to that institution it would be required to provide justification satisfactory to the Secretary that a reasonable return was received for the excess payment.

Where the HMO finds this a more feasible and economical arrangement, it would have the alternative of letting the Social Security Administration pay for part A institutional services directly under the medicare payment system, and charge the HMO's account for such services.

The committee notes that some HMO's will provide a substantial number of services to non-HMO enrollees on a fee-for-service basis and that there will also be cases in which, although the HMO itself might not be providing substantial amounts of such services to non-enrollees, the physicians with whom the HMO enters into contractual arrangements to provide comprehensive services, and the facilities used to provide such services, may be identical with those used to provide fee-for-service services to non-enrollees. Such situations would raise the possibility of an HMO's encouraging high-risk individuals to withdraw from the HMO with the understanding that they receive the

same services from the same individuals and in the same setting, but have payment made under the regular medicare program. One method of preventing this type of situation would be to place limits on reimbursement under the regular medicare program in such cases. However, the committee does not think this would be desirable. Nor does it want to prohibit an HMO from providing services to non-enrollees on a fee-for-service or other non-capitation basis. Rather, it intends that the Secretary identify HMO arrangements where the possibility of this type of situation exists, and establish policies—such as a requirement for statistical comparisons of the cost and utilization of HMO and non-HMO beneficiaries in such settings—which would minimize the likelihood of, and facilitate identification of this type of problem. If such abuse is found, and is not promptly rectified, the Secretary would be expected to report his experience with such problems in his reports to the Congress on the HMO provision.

In general, medicare reimbursement principles applicable to overhead items would be applied in determining acceptable HMO costs. In view of the open enrollment requirements under which HMO's will need to communicate with medicare beneficiaries in their service areas regarding open enrollment periods, reasonable costs incurred in satisfying the open enrollment requirement would be treated as allowable administrative costs. On the other hand, any reinsurance costs—including underwriting of risk above 100 percent of adjusted average per capita costs—would not be treated as allowable cost for HMO cost determination purposes with the exception of reinsurance of out-of-area costs.

Before approving an HMO for contracting on an incentive per capita reimbursement basis the HMO should submit evidence that it is financially responsible and will be able to carry out its contractual commitments. The committee believes that, at a minimum, the HMO should be able to present evidence satisfactory to the Secretary of capacity to assume its proportionate share of risk on up to 20 percent above total estimated adjusted average per capita costs during the prospective medicare year. This could include calculations based upon capacity to provide covered services apart from actual financial resources. Also, an HMO should not be permitted to switch back and forth between the per capita rate reimbursement system and the regular cost reimbursement system, depending upon which appears more advantageous at any particular time. Accordingly a provision has been added to permit an HMO which has commenced contracting on a risk-sharing basis to switch back to the regular reimbursement basis but subject to the condition that it could not again be accepted to contract on a per capita rate basis.

Definition of HMO

Under the House and committee bill, to qualify for reimbursement as an HMO, the organization must be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis and (2) physician's services, for the most part, rendered 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. It is expected that such payment arrangement would 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.) Some specialist physician services could, as is often the case in existing HMO's, be purchased from physicians as needed on a fee-for-service or fee-for-time basis.

Other provisions in the House and committee bill require that the various elements of a health maintenance organization, such as the hospital, the skilled 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. Also, 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 of positive and continuing efforts to achieve the required enrollment distribution. 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 proper quality standards.

Under the committee provision, the HMO would have to maintain an appropriate mix of primary care and specialty care physicians in relation to its size and in relation to the physician manpower mix in the general geographical area; physicians should not be classified as specialists unless they are board certified or eligible for specialty board certification; provided, however, that for good cause and under unusual circumstances the Secretary might recognize a physician as a specialist if, in fact, such physician can show substantial equivalence of training and experience, and a record of demonstrated proficiency.

The HMO would be expected to assure that the appropriate mix of specialists is properly assigned and utilized. Thus, for example, in an area where major surgery is generally done by board eligible or board certified surgeons, the same situation should prevail in the HMO except in cases of emergency or other highly unusual circumstances.

The HMO should have effective referral arrangements to assure that members would, in cases of medical necessity, have access to qualified practitioners in those specialties which are generally available to the general public in the service area but not included within professional staff directly associated with the HMO.

The committee made clarifying modifications in two other portions of the House definition of a health maintenance organization. A provision of the House bill which would require the HMO to provide all the services and benefits covered under both part A and part B has been modified to require it to provide all such services which are generally available to persons residing in the area served. Thus, for example, if there were no home health agency in the area, the HMO would not be required to create such an agency solely for its medicare enrollees. The committee also modified a House requirement that the HMO hold an

annual open enrollment period during which applicants would be accepted on a nondiscriminatory basis up to the limits of capacity. The House bill authorizes an exception to this requirement if acceptance of all applicants would result in an HMO enrollment of more than 50 percent of individuals over age 65; the committee would also permit the HMO to limit acceptance of applicants from any particular age group to prevent its membership from becoming substantially non-representative of the geographic area which it serves. Generally, a subgroup of enrollees would not be considered to be non-representative unless its proportion among all enrollees exceeds by at least 10 percent its proportion in the general population in the area.

Other Provisions

The committee agrees with the House that the Secretary should 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 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 avoid any possibility of beneficiaries being deprived of benefits through devices such as scheduling appointments at inconvenient times or 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.

In addition, while the committee recognizes the desirability of permitting considerable latitude in organizational arrangements, it also expects that the Secretary's regulations will require organizations, such as medical foundations, which furnish a significant amount of institutional or other services under arrangements, to provide sufficient management and coordination of services to assure that the full range of covered care, to the extent generally available in an area, is provided as needed to the beneficiary population.

The individuals with respect to whom medicare would pay capitation payments are medicare beneficiaries who are entitled to both hospital insurance and supplementary medical insurance or to medical insurance only and who are enrolled with an HMO. Under the House bill, such enrollees would receive medicare-covered services only through the health maintenance organization, except for those emergency services as are furnished by other physicians and providers of services. The HMO would be responsible for paying the costs of such emergency services.

The committee has made this House-passed requirement applicable to HMO's which have contracted on a risk-sharing basis and has added a provision which would also require the HMO to assume expenses for "urgently needed" services received by a medicare enrollee who is temporarily outside the HMO's service area. Services covered under this provision would generally be those services which, while not "emergency" to the extent of requiring use of the most accessible hospital in order to prevent death or serious impairment of health, are nevertheless immediately necessary to prevent serious deterioration of health and cannot feasibly be provided at the HMO's treatment facili-

ties because of the beneficiary's temporary absence from the service area, such as during a vacation trip. If an enrolled individual received care other than emergency or urgently needed services, 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 HMO which should have been furnished by it but was not made reasonably available.

The committee recognizes that many medicare beneficiaries are highly mobile, so that restrictions on out-of-area coverage by the HMO may well be seen by beneficiaries as a serious disadvantage and may also be difficult for beneficiaries to fully understand when they are considering whether to enroll in an HMO. It is also recognized that an HMO would generally have little chance of exercising control over costs of urgently needed services received by medicare beneficiaries, other than through restrictions on the extent to which such services are covered. Therefore, in order to encourage an HMO to provide as full coverage of urgently needed out-of-area services as it feasibly can, it would be permitted to reinsure such costs, provided that its coverage of them meets the minimum requirements which the Secretary would establish in regulations. Also, the Secretary would be expected to consider the feasibility of permitting HMO's to enter into arrangements to have payment for out-of-area services to beneficiaries made through the regular medicare program, with appropriate adjustments made in the HMO's account; the Secretary would be authorized to implement such a system, if he determined that it would be administratively feasible.

The committee also realizes that some HMO's may not be able to provide urgently needed services to beneficiaries who are temporarily outside their service area, because they cannot obtain reinsurance for these costs or for other good reasons. While under the House bill an HMO that could not provide emergency services to such beneficiaries could not qualify as an HMO, the committee believes that such a result would be unfortunate, especially since there does not seem to be a very strong precedent for coverage of such services among prototype HMO's. The committee believes that otherwise qualified organizations that are unable, for good reason, to provide coverage of urgently required services furnished outside the HMO area should nevertheless be permitted to participate as HMO's. In such cases, out-of-area covered services received by beneficiaries enrolled in such an HMO would be payable under the regular medicare program. The capitation payable to such organizations should be adjusted to exclude an amount estimated to represent costs of covered services which the HMO's beneficiaries receive outside the HMO's service area. The committee would expect the Secretary to take any necessary precautions to assure that this provision was not used by HMO's to encourage beneficiaries to secure certain high-cost medically necessary services from outside the HMO.

If the HMO provides only the services covered by the medicare program to its enrollees, the premiums or other charges it makes to its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program which the plan covers in its enrollment charge. Beneficiaries could not be charged premiums

for covered services which include cost-sharing on non-covered types of expense such as the maternity expense factor in hospital care. 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 or other charges 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. Any portion of the actuarial value of deductibles and coinsurance which the HMO may assess at the time individual services are rendered may not exceed the actuarial value of medicare copayments. Under the House bill, the HMO could require a medicare beneficiary to accept and pay for coverage of services in addition to medicare benefits as a condition of enrollment. The committee believes that such a condition could place undue financial hardship on some medicare beneficiaries and has therefore modified the provision to make acceptance of a supplemental benefit package optional with the beneficiary. These requirements are intended to assure that beneficiaries enrolled with an HMO 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 beneficiaries who elect additional benefits are made aware of the exact cost of the supplemental coverage provided by the HMO.

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 maintenance 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, to the extent practicable, disenrollment would be patterned after the disenrollment procedure as is followed now with respect to disenrollment under the supplementary medical insurance program.

The committee also agrees with the concern reflected in the House bill that some organizations potentially qualified to contract on an incentive basis 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 disenroll immediately or involuntarily accept a limitation on their access to covered services, the committee has included a provision under which a health maintenance organization which has contracted on an incentive basis could continue through June 1976 to be reimbursed for covered care provided to beneficiaries who were members prior to July 1973 but who do not elect the option. For beneficiaries who do not elect the option, the usual capitation payment would be subject to additional actuarial adjustment to reflect projected use of out-of-plan services to the extent that such services would have been considered sufficiently reasonable and necessary to be provided by the HMO under the rules of that organization. Retroactive adjustment would be made at the end of the year to reflect actual expenses of the type otherwise reimbursable under the program incurred on behalf of such beneficiaries. Any savings or losses (and related apportionment thereof) would be determined

by comparing the HMO's actual incurred per capita costs, increased by a factor reflecting the costs of sufficiently reasonable and necessary out-of-plan services received by such beneficiaries, with the adjusted average per capita cost.

While the modifications and additional safeguards which have been included establish the potential for effective administration of the HMO provision, the committee nevertheless recognizes that use of the HMO approach to provision of health care services remains relatively unknown in many geographic areas. Accordingly, the committee believes that the Congress should be kept fully informed of program experience with the HMO provision so that appropriate modifications, as required, can be made as expeditiously as possible. It has, therefore, added a provision which would require the Secretary of Health, Education, and Welfare to report to the Congress within a reasonable period after the first annual reports by HMO's are received, and annually thereafter, in the HEW annual report, regarding experience with the HMO provision. Such reports should include general evaluation of the HMO provision in operation, and should specifically cover cost experience, quality of care considerations, numbers of beneficiaries who enroll, enrollment trends, and other relevant information including evaluation of the performance of the different types of HMO's. Enrollment trends are particularly significant as the medicare program would not benefit directly in a financial sense from the possible efficiencies of HMO's until a substantial number of medicare beneficiaries not presently enrolled choose to enroll in such organizations.

The committee expects that the Department will provide technical assistance, particularly with regard to matters concerning determination of proper actuarial rates, to assist States participating in the title XIX program to enter into contracts with HMO's (eligible as such under medicare) to provide services to medicaid eligibles where a State requests such assistance. The Federal Government would assume the cost of such technical and actuarial assistance as is necessary.

The provision would become effective with respect to services provided on or after July 1, 1973.

Repeal of Section 1902(d) of Medicaid

(Sec. 231 of the bill)

Under section 1902(d) of the medicaid law, a State may reduce the range, duration or frequency of the services it provides under its medicaid program, but it cannot reduce its aggregate expenditures for the State share of its medicaid program from 1 year to the next. Failure to comply with this requirement means ineligibility for Federal medicaid matching funds.

The House bill restricts the application of section 1902(d) to the mandatory health care services which all State medicaid programs must make available to eligible recipients. The House provision would permit a State to modify the scope and extent of such optional services as drugs, dental care and eyeglasses, but it could not reduce the amount of expenditures for the mandatory services.

The committee has been concerned about the effect of section 1902 (d) on States which may be faced with fiscal crises. Further, the committee believes that the maintenance of effort provision of section 1902(d) functions as a barrier to orderly development and operation of State programs, and that States are generally best able to determine the changing needs of their people.

The committee has therefore substituted for the House provision an amendment repealing section 1902(d). This action is consistent with the committee and Senate action on H.R. 17550 in 1970.

The committee does not expect that removal of the maintenance of effort requirement will result in large-scale cut-backs in benefits under the medicaid program, but it does believe that elimination of this provision will provide States with greater flexibility to design their programs to meet effectively the needs of their people for medical care within the fiscal constraints faced by given States from time-to-time.

Payments to States Under Medicaid for Development of Cost Determination Systems for State-Owned General Hospitals

(Sec. 235 of the bill)

Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. 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.

Section 235 as approved by the House authorizes 90 percent Federal matching for the cost necessary to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary and 75 percent Federal matching for the operation of systems 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. In addition, section 235 would provide 90 percent Federal matching during fiscal years 1972 and 1973 for the cost of design, development, or installation of cost determination systems for State-owned general hospitals, with total funds paid to all States under this clause not exceeding \$150,000 in either year.

Although the committee acknowledges the obligation of the Federal Government to provide technical assistance to each State operating a medicaid program, it believes that the inducements of more efficient and effective administration of the program, and resulting reductions in program costs, should be sufficient to stimulate States to implement mechanized claims processing and information retrieval systems under the matching provisions of current law. Further, possible major changes in the nature and allocation of administrative responsibilities under medicaid during the next several years might quickly render such systems obsolete.

Therefore, the committee has deleted all of section 235 except for

the provision authorizing funds for cost-determination systems for State-owned general hospitals (such as that being undertaken by the State of Mississippi).

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

(Sec. 237 of the bill)

Under medicare, 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 validity to review of medicaid cases, but there is now no such requirement in the medicaid law. Under medicaid, the medical assistance unit of the State agency administering the medicaid program is responsible for all utilization review plans and activities under the medicaid program. The medical assistance unit may in lieu of establishing its own utilization review system delegate utilization review responsibilities for inpatient hospital and skilled nursing home care to the agency which monitors utilization review activities for such services under medicare.

The committee approved in H.R. 17550, and supports again in H.R. 1, the House provision which 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 review group which meets the standards established under medicare. However, the committee does not intend that where medicaid requires more stringent or comprehensive utilization review than does medicare, such requirements be reduced by virtue of operation of this section. Several States have developed and are applying utilization review procedures, different from the medicare utilization review committees, which have met with some success. The committee has, therefore, modified the House bill to provide that until such time as professional standards review organizations are operational in the States, the Secretary may waive the requirements of this section to permit States to substitute alternative utilization review systems where it can be demonstrated to his satisfaction that the alternative systems will be superior in effectiveness to the medicare requirement. To avoid duplication of review activity in such cases, the Secretary might also require usage where appropriate of the more effective medicaid review method for medicare patients as well, in lieu of the regular medicare procedure.

This provision would be effective January 1, 1973.

Program for Determining Qualifications for Certain Health Care Personnel

(Sec. 241 of the bill)

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 regulations have relied heavily on formal training courses and professional society membership in judging professional competency.

In the report of this committee on the Social Security Amendments of 1967 (H.R. 12080), the committee agreed with the Secretary that appropriate criteria as prima facie evidence of competence are necessary. However, the committee expressed concern 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. The committee pointed out in 1967 that failure to make the fullest use of competent health personnel was of particular concern because of the shortage of such personnel.

In 1967, the committee recommended that the Secretary of Health, Education, and Welfare consult with appropriate professional health organizations and State health agencies and, to the extent feasible, explore, develop, and apply appropriate means—including testing procedures—for determining the proficiency of health care personnel otherwise disqualified or limited in responsibility under regulations of the Secretary. Moreover, the committee instructed the Secretary to encourage and assist programs designed to upgrade the capabilities of those not sufficiently skilled to qualify initially but who could perform satisfactorily and qualify on a proficiency basis with relatively little additional training.

However, despite that formal instruction and expectation of the committee the Department of Health, Education, and Welfare has since 1967 continued to rely almost entirely on formal training and professional society membership in measuring the qualifications of health care personnel. The Department has taken little or no action, except with respect to directors of clinical laboratories and to physical therapists in developing proficiency testing and training courses. The personnel problems which existed in 1967 and which the committee sought to alleviate, have been aggravated as a result of the Department's continued inaction.

The Medical Services Administration issued a ruling effective July 1, 1970, concerning licensed practical nurses in skilled nursing homes participating in medicaid. Nursing homes, according to the ruling, must have as charge nurses for each shift (other than the day shift which requires a registered nurse) a registered nurse or a licensed practical nurse, with a degree from a State-accredited school or its equivalent. There is an acute shortage of nursing personnel, and many hundreds of nursing homes have been covering some shifts with "waivered" practical nurses. These are practical nurses, who do not have the required formal training, and who, in many States, have been licensed on a waived basis. Undoubtedly, a substantial proportion of these practical nurses have years of experience and are competent; obviously, other waived practical nurses are not competent to serve as charge nurses.

As noted, the Department of Health, Education, and Welfare has taken no action since 1967, in developing proficiency testing or short-term supplemental training for these personnel, and consequently, many otherwise qualified nursing homes are being, or soon may be,

forced out of the program because of their inability to locate a registered nurse or a licensed practical nurse. Problems somewhat similar to those confronting waived licensed practical nurses exist with respect to some therapists, medical technologists, and psychiatric technicians.

In view of this, the committee approved a provision in 1970, included in H.R. 17550 as passed by the Senate, which would require the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations, and regularly report to the committee and to the Committee on Ways and Means of the House of Representatives concerning the Department's progress in this area.

Except for the time limit described, the House bill includes this provision. The committee has modified the House provision by again setting a time limit—December 31, 1977—beyond which determinations of proficiency would not apply with respect to persons initially licensed by a State or seeking initial qualification as a health care person. In addition, the committee specified that cytotechnologists were intended to be included among the types of health personnel to which the proficiency testing would apply.

The committee would emphasize again its concern that only qualified personnel be utilized in providing care under medicare and medicaid. However, appropriate methods and procedures are capable of being promptly developed and applied to determine qualifications and to upgrade skills to qualifying levels. The committee does not advocate "grandfathering" of poorly qualified health care personnel nor does it advocate usage of arbitrary and inflexible cut-off standards of qualification which rule out of program participation many competent personnel.

Reimbursement Appeals by Providers of Services

(Sec. 243 of the bill)

Under present law a fiscal intermediary determines the amount of reasonable cost to be paid to a provider of services. There is no specific legislative provision for an appeal by the provider of the intermediary's final reasonable cost determinations. Although the Social Security Administration has instituted certain administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, the committee believes that it is desirable to prescribe in law a specific appeals procedure for disputed final settlements applying to reasonable cost determinations. This procedure does not apply to questions of coverage or disputes involving individual beneficiary claims.

The committee has therefore approved, with modifications, a provision in the House bill which would provide for the establishment of the Provider Reimbursement Review Board. The Board would be composed of five members, knowledgeable in the field of health care reimbursement, appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board would be a certified public accountant. The Secretary would select two of the members from qualified and acceptable nominees of the providers. The Provider Reimbursement Review Board would be authorized to make rules and

establish procedures necessary to its operation in accordance with regulations established by the Secretary of Health, Education, and Welfare.

Under the House bill, any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary to the Board where the amount at issue is \$10,000 or more. The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination. The committee modified this portion of the provision by including two additional situations which could serve as a basis for provider appeals. The first provision would enable groups of providers to appeal adverse final decisions of the fiscal intermediary to the Board where the amount at issue aggregates \$10,000 or more. The second modification enables any provider which believes that its fiscal intermediary has failed to make a timely cost determination on its annual cost report, if such report is substantially in proper order, or a timely determination on an acceptable supplemental filing where the initial filing was deficient, to appeal to the Board where the amount involved is \$10,000 or more. Implementation of the intermediary determinations would not be held in abeyance pending the Board's decision.

The provider shall have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing. It may be represented by counsel and introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary. Reasonable opportunity to examine and cross-examine witnesses shall be provided. All decisions by the Board shall be based upon the record made at such hearing which may include any evidence submitted by the Department. Such evidence shall include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, such 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 or Government 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 Procedures Act, notwithstanding any other provision in section 205 of the Social Security Act.

The amendment would become effective with respect to accounting periods beginning on or after July 1, 1972.

Physical Therapy and Other Therapy Services Under Medicare

(Sec. 251 of the bill)

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 outpatients. The physical therapist may either be 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 House bill would provide for coverage, under the supplementary medical insurance program, of up to \$100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or in the patient's home under a physician's plan. Reimbursement for the reasonable charges for the covered services rendered by the physical therapist would be made either to the beneficiary or, on assignment, directly to the physical therapist.

The committee has been advised by the Department of Health, Education, and Welfare that the House provision would be difficult to administer in terms of assuring the provision of appropriate services, or of effectively enforcing the health, safety, and quality safeguards embodied in present law, since physical therapists would be furnishing services outside the controlled environment of an institutional setting or responsibility. Moreover, this provision would compound the already costly and troublesome problem of restraining overutilization and inappropriate utilization of physical therapy services. The committee agrees with the Department that at the present time whatever advantage might accrue to beneficiaries from increased availability of services would be at the expense of higher benefit and administrative costs. For these reasons, the committee has deleted this special \$100 feature of the House bill.

The committee is concerned about the few cases under present law where an inpatient exhausts his inpatient benefits or where he is otherwise ineligible for hospital insurance inpatient benefits and can continue to receive supplementary medical insurance reimbursement for physical therapy treatment 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. The House bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients in the above categories. The committee concurs with the House bill on this provision and the effective date for this subsection would make the provision effective for services furnished after enactment of the bill.

The House bill also includes a provision for controlling program expenditures and for preventing abuses. Under this provision payment for the reasonable cost of 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 under arrangements with others to supply such services, may not exceed an amount equivalent to the salary and other costs which would reasonably have been payable if the services had been performed in an employment relationship, plus the cost of such expenses an individual not working as an employee might have, such as maintaining an office, traveltime and expense, and similar costs.

The committee concurs with the House amendment, which reflects the changes made by the committee during its consideration of H.R. 17550, the Social Security Amendments of 1970. The committee

expects—as does the Committee on Ways and Means—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. Further, the committee expects that the Secretary will establish salary equivalents by appropriate geographic areas (including, where appropriate and feasible rural and urban distinctions) and that such amounts will be set at the 75th percentile of the range of salaries paid in the area to therapists working full-time in an employment relationship, with such additional or adjusted allowance for salaries paid to therapists whose duties are supervisory or administrative in nature, as the Secretary finds to be appropriate. To the extent feasible, timely, and accurate, salary data compiled by the Bureau of Labor Statistics would be used in determining the 75th percentile level of salaries in an area. If a provider requires the services of a physical therapist on a limited part-time basis or only to perform intermittent services the Secretary may make payment on the basis of a reasonable rate per unit of service greater per unit of time than salary equivalent amounts where he finds that such greater payment is in the aggregate less than would have resulted if the provider employed a therapist on a full or part-time salaried basis.

The above provision would be effective with respect to accounting periods beginning on or after January 1, 1973.

Collection of Supplementary Medical Insurance Premiums From Individuals Entitled to Both Social Security and Railroad Retirement Benefits

(Sec. 263 of the bill)

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 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 part A only and the other 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 of 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.

The committee agrees with the provision in the House bill which 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.

Under the House bill the Railroad Retirement Board would be authorized to 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. However, in the interest of program efficiency, economy, and consistency of administration in an area, the committee bill would delete that part of the provision which grants the Railroad Retirement Board authority to choose the carrier for part B benefits for its beneficiaries so that the Secretary of Health, Education, and Welfare would continue to have this authority.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

Waiver of Requirement of Registered Professional Nurses in Skilled Nursing Facilities in Rural Areas

(Sec. 267 of the bill)

Under current law, a skilled nursing facility certified to participate in the medicaid program is required to maintain an organized nursing service under the direction of a registered professional nurse who is employed full time. The law requires the nursing service to be composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services to patients during all hours of each day and all days of each week. The House was concerned that this requirement posed special problems for skilled nursing facilities in rural areas where there is inadequate availability of registered nurses to staff a facility and therefore authorized a waiver of the requirement for a full-time registered nurse in rural skilled nursing homes.

While the committee recognizes the difficulty faced by many rural skilled nursing facilities in obtaining necessary nursing staff, the committee also believes it necessary to safeguard the patient whose nursing needs warrant continuing care by a registered nurse, such as those patients requiring administration of potent injectable and intravenous medications or medicinal gases on a regular basis, maintenance of tracheotomies or gastrotomies, tubal feeding, etc.

In recognition of the staffing difficulties of the rural skilled nursing facilities, the committee amendment provides that, to the extent

that law or regulation requires the presence of a registered nurse on one full-shift 7 days a week, a special waiver of the nursing requirement for these facilities may be granted provided that a registered nurse is absent from the facility for not more than two day-shifts (if the facility employs one full-time registered nurse) and the facility is making good faith efforts to obtain another on a part-time basis. The American Nurses Association has indicated that State nurses' associations would willingly cooperate in efforts to secure necessary nursing personnel; the committee expects that, to the extent such cooperation is extended it will be utilized toward alleviating a skilled nursing shortage in a facility.

Additionally, to protect those patients who may need daily skilled nursing care, this special waiver may be granted only if (1) the facility is caring only for patients whose physicians have indicated (in written form on order sheet and admission note) that they could go without a registered nurse's services for a 48-hour period or (2) if the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, the facility has made arrangements for a registered nurse or a physician to spend such time as is necessary at the facility to provide the skilled nursing services required by patients on the uncovered day.

Coverage of Chiropractic Services Under Medicare

(Sec. 273 of the bill)

Under the House bill, the Secretary would be required to conduct a study of chiropractic services covered under State plans approved under title XIX. The study would 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 furnished. The Committee on Finance believes, however, that further study of chiropractic services is not required to support coverage of the services of chiropractors under the supplementary medical insurance program.

In providing coverage for the services of chiropractors, the committee recognizes the need for controls on the quality, cost, and utilization of such services. Accordingly, the committee bill would broaden the definition of the term "physician" in title XVIII to include a licensed chiropractor who also meets uniform minimum standards to be promulgated by the Secretary. The committee believes that at least uniform minimum standards of the following kinds should underlie licensure: satisfactory evidence of preliminary education equal to the requirements for graduation from an accredited high school or other secondary school; a diploma issued by a college of chiropractic approved by the State's chiropractic examiners and where the practitioner has satisfied the requirements for graduation including the completion of a course of study covering a period of not less than three school years of six months each year in actual continuous attendance covering adequate courses of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chem-

istry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and passage of an examination prescribed by the State's chiropractic examiners covering said subjects. Moreover, the committee does not intend that the practice of operative surgery, osteopathy, or administering or prescription of any drug or medicine included in materia medica should be covered by the practice of chiropractic. Such standards would also be applicable to coverage of chiropractic services under medicaid.

The services furnished by chiropractors would be covered under the program as "physicians' services," but only with respect to treatment of the spine by means of manual manipulation which the chiropractor is legally authorized to perform. As with other program benefits, the committee is aware of the possible overutilization of chiropractic services, and expects that the Secretary will issue guidelines to medicare carriers for use in review of bills for such services, to assure proper usage of the benefit.

The amendment would become effective with respect to services provided on or after July 1, 1973.

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

Professional Standards Review

(Sec. 249F of the Bill)

According to recent estimates the costs of the medicare hospital insurance program will overrun the estimates made in 1967, by some \$240 billion over a 25-year period. The monthly premium costs for part B of medicare—doctors' bills—rose from a total of \$6 monthly per person on July 1, 1966, to \$11.60 per person on July 1, 1972. Medicaid costs are also rising at precipitous rates.

The rapidly increasing costs of these programs are attributable to two factors. One of these is an increase in the unit cost of services such as physicians' visits, surgical procedures, and hospital days. H.R. 1, as reported, contains a number of desirable provisions which the committee believes should help to moderate these unit costs.

The second factor which is responsible for the increase in the costs of the medicare and medicaid programs is an increase in the number of services provided to beneficiaries. The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

REVIEW OF PRESENT UTILIZATION CONTROLS

The committee has found that present utilization review requirements and activities are not adequate.

Under present law, utilization review by physician staff committees in hospitals and extended care facilities and claims review by medicare carriers and intermediaries are required. These processes have a number of inherent defects. Review activities are not coordinated between medicare and medicaid. Present processes do not provide for an integrated review of all covered institutional and noninstitutional services which a beneficiary may receive. The reviews are not based upon adequately and professionally developed norms of care. Additionally, there is insufficient professional participation in, and support of, claims review by carriers and intermediaries and consequently there is only limited acceptance of their review activities. With respect to the quality of care provided, only institutional services are subject to quality control under medicare, and then only indirectly through the application of conditions of participation.

Under present law, each hospital and extended care facility must have a utilization review plan covering services provided to medicare patients which provides for review, on a sample or other basis, of admissions, duration of stays, and the professional services furnished. The review is to include consideration as to the medical necessity of the services and the efficient use of health facilities and services. The utilization review is undertaken by either (1) a group, including at least two physicians, organized within the institution or (2) a group (including at least two physicians) organized by a local medical society or other group approved by the Secretary of Health, Education, and Welfare. The statute provides also that the utilization review group must be organized as in (2) above, if the institution is small or for such other good reasons as may be included in regulations. The utilization review group must also review long-stay cases and inform those concerned (including the attending physician) when it determines that hospitalization or extended care is no longer medically necessary.

The Finance Committee and the Ways and Means Committee stressed in 1965 that these requirements, if effectively carried out, would discourage improper and unnecessary utilization. The Finance Committee Report (S. Rept. 404, pt. I, 89th Cong., p. 47) stated:

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

The detailed information which the committee has collected and developed as well as internal reports of the Social Security Administration indicate clearly that utilization review activities have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The pres-

ent situation has been aptly described by a State medical society in these words :

Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token.

The current statute places upon the intermediary as well as the State health agency responsibility for assuring that participating hospitals and extended-care facilities effectively perform utilization review.

Available data indicate that in many cases intermediaries have not been performing these functions satisfactorily despite the fact that the Secretary may not, under the law, make agreements with an intermediary who is unwilling, or unable, to assist providers of services with utilization review functions.

Apart from the problems experienced in connection with their determinations of "reasonable" charges, the performance of the carriers responsible for payment for physicians' services under medicare has also varied widely in terms of evaluating the medical necessity and appropriateness of such services. Moreover, ever since medicare began, physicians have expressed resentment that their medical determinations are challenged by insurance company personnel. The committee has concluded that the present system of assuring proper utilization of institutional and physicians' services is basically inadequate. The blame must be shared between failings in the statutory requirements and the willingness and capacity of those responsible for implementing what is required by present law.

There is no question, however, that the Government has a responsibility to establish mechanisms capable of assuring effective utilization review. Its responsibility is to the millions of persons dependent upon medicare and medicaid, to the taxpayers who bear the burden of billions of dollars in annual program costs, and to the health care system.

In light of the shortcomings outlined above, the committee believes that the critically important utilization review process must be restructured and made more effective through substantially increased professional participation.

The committee believes that the review process should be based upon the premise that only physicians are, in general, qualified to judge whether services ordered by other physicians are necessary. The committee is aware of increasing instances of criticism directed at the use of insurance company personnel and Government employees in reviewing the medical necessity of services.

The committee generally agrees with the principles of "peer review" enunciated in the report of the President's Health Manpower Commission, issued in November 1967. That report stated :

Peer review should be performed at the local level with professional societies acting as sponsors and supervisors.

Assurance must be provided that the evaluation groups perform their tasks in an impartial and effective manner.

Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.

The more objective the quality evaluation procedures, the more effective the review bodies can be. To enable greater objectivity, there should be a substantial program of research to develop improved criteria for evaluation, data collection methods, and techniques of analysis.¹

The committee has therefore included an amendment, as it did in H.R. 17550, which authorizes the establishment of independent professional standards review organizations (PSRO's) by means of which practicing physicians would assume responsibility for reviewing the appropriateness and quality of the services provided under medicare and medicaid.

THE COMMITTEE PROVISION

The committee has provided for a review mechanism through which practicing physicians can assume full responsibility for reviewing the utilization of services. The committee's review mechanism at the same time contains numerous safeguards intended to fully protect the public interest.

The committee provision would establish broadly based review organizations with responsibility for the review of both institutional and outpatient services, as opposed to the present fragmented review responsibilities.

The new review organizations would be large enough to take full advantage of rapidly evolving computer technology, and to minimize the inherent conflicts of interest which have been partially responsible for the failure of the smaller institutionally based review organizations. The review process would be made more sophisticated through the use of professionally developed regional norms of diagnosis and care as guidelines for review activities, as opposed to the present usage of arbitrarily determined checkpoints. The present review process, without such norms, becomes a long series of episodic case-by-case analyses on a subjective basis which fail to take into account in a systematic fashion the experience gained through past reviews or to sufficiently emphasize general findings about the pattern of care provided. The committee believes that the goals of the review process can be better achieved through the use of norms which reflect prior review experience.

The committee's bill provides specifically for the establishment of independent professional standards review organizations (PSRO's) formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for the review of service (but not payments) provided through the medicare and medicaid programs.

Recognizing the problem, on their own, a number of medical societies and other health care organizations have already sponsored similar types of mechanisms for purposes of undertaking unified and coordinated review of the total range of health care provided patients. Additional medical societies are proceeding to set up such organizations.

In reaffirming its conviction that the establishment of PSRO's should result in important improvements to the medicare and medicaid programs, the committee has taken particular note of the progress which has been made by a number of prototype review organizations

¹ Report of the Health Manpower Commission, November 1967, p. 48.

across the country. Experience by these organizations has provided the committee with convincing evidence that peer review can—and should—be implemented on an operational, rather than merely an experimental basis.

The committee expects that in developing the policies and regulations implementing the PSRO provision, the Secretary will seek the advice and counsel of physicians and administrators connected with existing successful review organizations.

However, in most parts of the country, new organizations would need to be developed.

The committee would stress that physicians—preferably through organizations sponsored by their local associations—should assume responsibility for the professional review activities. Medicine, as a profession, should accept the task of advising the individual physician where his pattern of practice indicates that he is overutilizing hospital or nursing home services, overtreating his patients, or performing unnecessary surgery.

It is preferable and appropriate that organizations of professionals undertake review of members of their profession rather than for Government to assume that role. The inquiry of the committee into medicare and medicaid indicates that Government is ill equipped to assure adequate utilization review. Indeed, in the committee's opinion, Government should not have to review medical determinations unless the medical profession evidences an unwillingness to properly assume the task.

But, the committee does not intend any abdication of public responsibility or accountability in recommending the professional standards review organizations approach. While persuaded that comprehensive review through a unified mechanism is necessary and that it should be done through usage, wherever possible and wherever feasible, of medical organizations, the committee would not preclude other arrangements being made by the Secretary where medical organizations are unwilling or unable to assume the required work or where such organizations function not as an effective professional effort to assure proper utilization and quality of care but rather as a token buffer designed to create an illusion of professional concern.

In a number of areas of the country, carriers and intermediaries—even though their activity is limited to retrospective review—are doing a reasonably effective job of controlling unnecessary utilization of health care services. Such efforts should not be terminated in any area until such time as a PSRO has satisfactorily demonstrated the willingness, operational capacity, and performance to effectively supplant and improve upon existing review work. Even where the PSRO becomes the paramount review organization, the existing review, if it is efficient and effective, should not be dismantled, if the PSRO can benefit by utilizing its experience and services.

ESTABLISHMENT OF PSRO's

The amendment requires the Secretary, following consultation with national, State and local, public and private medical care organizations, and medical societies, to tentatively designate PSRO areas throughout the country by January 1, 1974. In smaller or more sparsely populated States, the designations would probably be on a

statewide basis. Each area, defined in geographic or medical service area terms, would generally include a minimum of 300 practicing physicians—in most cases substantially more than that number. Because of the minimum number of physicians required—intended to assure broad, diverse, and objective representation—it is expected that there will be many multicounty PSRO areas.

Tentative area designations could be modified if, as the system was placed into operation, changes seemed desirable. Area designations would also take into consideration the need to assure a reasonably coordinated administrative arrangement among PSRO's and the various medicare and medicaid administrative mechanisms in a State or area. The Secretary would provide prototype plans of organization and operation to prospective PSRO's in each area. The prototypes would be developed in consultation with proposed PSRO's and with various organizations presently operating comprehensive review mechanisms as well as national, State and local, private and public, health organizations.

It should be emphasized that in recommending operational, rather than experimental authority, it is recognized that the successful development of professional review organizations can encompass a variety of prototypes and that changes in technology can be expected to result in continued modifications in procedures, and that much remains to be done in the area of the development and refinement of professional norms. It is believed, though, that the proposal can be implemented within an overall framework of innovation and flexibility. The committee believes, further, that only a full implementation effort will provide the impetus needed to establish effective and equitable comprehensive professional review throughout the Nation.

Priority in designation as a PSRO would be given to organizations established at local levels representing substantial numbers of practicing physicians who are willing and believed capable of progressively assuming responsibility for overall continuing review of institutional and outpatient care and services. Local sponsorship and operation should help engender confidence in the familiarity of the review group with norms of medical practice in the area as well as in their knowledge of available health care resources and facilities. Furthermore, to the extent that review is employed today, it is usually at the local level. To be approved, a PSRO applicant must provide for the broadest possible involvement, as reviewers on a rotating basis, of physicians engaged in all types of practice in an area such as solo, group, hospital, medical school, and so forth.

Participation in a PSRO would be voluntary and open to every physician in the area. Existing organizations of physicians should be encouraged to take the lead in urging all their members to participate and no physician could be barred from participation because he is or is not a member of any organized medical group or be required to join any such group or pay dues or their equivalent for the privilege of becoming a member or officer of any PSRO nor should there be any discrimination in assignments to perform PSRO duties based on membership or nonmembership in any such organized group of physicians.

Physician organizations or groupings would be completely free to undertake or to decline assumption of the responsibilities of organizing a PSRO. If they decline, the Secretary would be empowered to seek alternative applicants from among other medical organizations, State

and local health departments, medical schools, and failing all else, carriers and intermediaries or other health insurers. In no case, however, could any organization be designated as a PSRO which did not have professional medical competence. And, in no case could any final adverse determinations by a PSRO with respect to the conduct or provision of care by a physician be made by anyone except another qualified physician.

PSRO physicians engaged in the review of the medical necessity for hospital care and justification of need for continued hospital care must be active hospital staff members. The purpose here is to assure that only doctors knowledgeable in the provision and practice of hospital care will review such care. To the extent feasible, it is intended that a physician not be involved in decisionmaking in the review of care for the PSRO which was provided in a hospital where he has active staff privileges (except to the extent of his involvement with "in-house" review acceptable to the PSRO).

The committee expects that the Secretary will provide every possible assistance to the PSRO's. The Department would be required to develop prototype review plans and would be expected to provide assistance and encouragement in the development of acceptable review plans. Proposals submitted to the Secretary by prospective PSRO's would be made available, on request, to appropriate concerned organizations and individuals who, in turn, would be free to submit to the Secretary such comments on the proposal as might assist his evaluation of the prospective PSRO. The Department would also be required to develop the capacity to evaluate the potential of review plans proposed by organizations throughout the country, and with the assistance and advice of the National Professional Standards Review Council, to monitor on a regular and continuing basis the performance of the organizations selected through the use of statistical comparisons and other means of evaluation.

The committee recognizes that proper administration of this provision will involve substantial administrative effort and expense. However, over the long run, the PSRO provision, properly implemented, should result in substantial reductions in program costs and improved quality of care. The Secretary is expected to take such administrative steps and provide all necessary assistance and cooperation to assure that no PSRO fails because it does not have access to the means or information required to perform adequately.

CONDITIONAL STATUS OF PSRO'S

A qualified PSRO applicant would be approved on a conditional basis for a period not to exceed 2 years during which it would develop and expand its review activities and capacity. Contracts may be terminated upon 90 days' notice by either the PSRO or the Secretary. During the conditional period, existing medicare and medicaid review operations would also continue so as to provide backup and standby capacity in the event a PSRO encounters difficulties or is terminated. At the end of the conditional period, where the PSRO has satisfactorily demonstrated its effectiveness in review, the Secretary would have authority and would be expected to waive any other professional review requirements, in whole or part, imposed under the law and regulations.

Medicare and medicaid claims-paying agencies would be expected to abide by final decisions of the PSRO during this trial period. Placing reliance on the PSRO decision during the trial period is necessary to permit an accurate appraisal of the effectiveness with which the conditionally approved PSRO's could be expected to exercise the review function in the absence of concurrent review by others.

As noted, once an organization is accepted as a PSRO the Secretary would regularly evaluate its performance using statistical comparison and other means of evaluation including the findings and recommendations of the statewide and national professional standards review councils established under the amendment. Where performance of an organization was determined to be unsatisfactory, and timely efforts to bring about its improvement failed, the Secretary could terminate its participation after appropriate notice and opportunity for administrative hearing. A finding, for example, that one PSRO was accepting without question substantial numbers of requests which other apparently well-run PSRO's were generally investigating and denying would be expected to result in termination of the agreement with the former PSRO unless the situation is justified by factors related to medical necessity or unless reasonable action to correct the problem is undertaken.

The committee anticipates that PSRO's will function in effective and dedicated fashion under the guidance of concerned physicians. In instances where there might be only nominal or halfhearted performance, it would be expected that necessary remedial action would be promptly taken through the initiative of the medical profession and, failing that, by the Secretary.

If the Secretary found it necessary to replace a review organization, as a first step he would consult with other review organizations in the State involved as well as with the State medical society to determine whether another local organization or an organization sponsored by the State society itself was willing and capable of undertaking review responsibility in the geographic area concerned. In the event that such was not the case, he could then contract with State or local health departments or employ other suitable professional means of assuring the necessary review activity in the area.

RESPONSIBILITIES OF A PSRO

A PSRO would have the responsibility of determining—for purposes of eligibility for medicare and medicaid reimbursement—whether care and services provided were: first, medically necessary, and second, provided in accordance with professional standards. Additionally, the PSRO where medically appropriate, would encourage the attending physician to utilize less costly alternative sites and modes of treatment. The PSRO would not be involved with questions concerning the reasonableness of charges or costs or methods of payment nor would it be concerned with internal questions relating to matters of managerial efficiency in hospitals or nursing homes except to the extent that such questions substantially affect patterns of utilization. The PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that medicare and medicaid payments will be made

only for medically necessary services which are provided in accordance with professional standards of care.

The local PSRO would be primarily responsible for review of all medicare and medicaid services rendered or ordered by physicians in its area. The purpose of the provision is to establish a unified review mechanism for all health care services under the aegis of the principal element in the health care equation, the physician. Christian Science practice, however, would not be encompassed in the overall review and review arrangements required of a PSRO.

In carrying out its responsibilities the PSRO would be required to regularly review provider and practitioner profiles of care and service (that is, the patterns of services delivered to medicare and medicaid beneficiaries by individual health care practitioners and institutions) and other data to evaluate the necessity, quality, and appropriateness of services for which payment may be made under the medicare and medicaid programs.

The PSRO would be expected to analyze the pattern of services rendered or ordered by individual practitioners and providers and to concentrate its attention on situations in which unnecessary, substandard, or inappropriate services seem most likely to exist or occur. Emphasis in review efforts would be related to the results expected to be achieved by these efforts so that the net advantage from the review time would be maximized.

A PSRO would have authority to approve the medical necessity of all elective hospital admissions in advance—solely for the purpose of determining whether medicare or medicaid will pay for the care. The PSRO would also be required to acknowledge and accept, in whole or in part, an individual hospital's own review of admissions and need for continued care, on a hospital-by-hospital basis, where it has determined that a hospital's "in-house" review is effective. It is expected that where such "in-house" review is effective this authority would be exercised by the PSRO. Similarly, a PSRO would be required to acknowledge and accept for its purposes, review activities of other medical facilities and organizations, including those internal review activities of comprehensive prepaid group practice programs such as the Kaiser Health plans and the Health Insurance Plan (H.I.P.) in New York to the extent such review activities are effective. In issuing regulations to assure orderly operation of this procedure of evaluating in-house review the Secretary would be expected to incorporate reasonable appeals procedures to avoid any non-professional prejudice or bias by the PSRO in acceptance or rejection of in-house review. In order to assure the broadest possible participation in PSRO activities by physicians in an area, internal review activities will not be accepted by a PSRO where the physicians of the institution or medical organization concerned do not participate in the overall review activities conducted by the PSRO. Thus an institution or medical organization which is carrying out effective review would bring its desirable expertise to the benefit of the entire community, to the extent that the PSRO finds those review activities and experience effectively assist in fulfilling its overall responsibilities.

The purpose here is to build upon and encourage improvement in existing systems of review to the extent those systems are capable of

assisting in fulfilling the overall responsibilities of a PSRO. Thus effective review mechanisms would be recognized and encouraged by the PSRO. Of course, PSRO's would use this authority carefully. Indiscriminate acceptance of hospital and other review activities would undoubtedly be reflected in an overall poor performance rating when a PSRO was measured against other PSRO's operating in careful fashion. A poor rating could, in turn, lead to termination and replacement of the negligent PSRO. Where provision of services was disapproved by the PSRO, payment for the services could not be made under medicare or medicaid (unless the disapproval was reversed in the course of reconsideration, hearing, or court review). In case of advance review the institution and the patient alike would know in advance whether medicare will pay for the health care services being contemplated, although denial of certification for admission would not bar admission of any patient to an institution if his physician desires to admit him and if the institution accepts his admission. In this regard, medicare parallels private health insurance where a private policy issuer might determine that the care proposed or rendered was not reimbursable under the terms of the policy.

Where advance approval by the review organizations for institutional admission was required and provision of the services was approved by the PSRO, or where and to the extent the PSRO accepted "in-house" review, such approval would provide the basis for a presumption of medical necessity for purposes of medicare and medicaid benefit payments. However, advance approval of institutional admission would not preclude a retroactive finding that ancillary services (not specifically approved in advance) provided during the covered stay were excessive.

The PSRO, where it has not accepted in-house review in a given hospital as adequate, would be responsible for reviewing attending physicians' certifications of need for continued hospital care beyond professionally determined regional norms directly related to patients' age and diagnoses, using criteria such as the types of data developed by the Commission on Professional and Hospital Activities, which is sponsored by the American Hospital Association, the American College of Physicians, and the American College of Surgeons. It is expected that such certification would generally be required not later than the point where 50 percent of patients with similar diagnoses and in the same age groups have usually been discharged. However, it is recognized that there are situations in which such stays for certain diagnoses may be quite short in duration. In such situations the PSRO might decide against requiring certification at or before the expiration of the period of usual lengths of stay on the grounds that the certification would be unproductive; for example, when the usual duration of stay is two days or less. Certification on the first day of stay might yield no significant advantage in the review process. This professionally determined time of certification of need for continued care is a logical checkpoint for the attending physician and is not to be construed as a barrier to further necessary hospital care. Neither should the use of norms as checkpoints, nor any other activity of the PSRO, be used to stifle innovative medical practice or procedures. The intent is not conformism in medical practice—the objective is reasonableness.

PSRO disapproval of the medical necessity for continued hospital care beyond the norm for that diagnosis will not mean that the physician must discharge his patient. The physician's authority to decide the date of discharge as well as whether his patient should be admitted in the first place cannot be and are not taken from him by the PSRO. The review responsibility of the PSRO is to determine whether the care should be paid for by medicare and medicaid. By making this determination in advance, the patient, the institution, and the physician will all be forewarned of the desirability of making alternative plans for providing care or financing the care being contemplated.

Similarly, as feasible, out-of-institution norms would be developed and utilized based upon patterns of actual and proper practice by physicians. Such norms are available in many areas to an extent today. It is recognized that continuing efforts will need to be made to improve the scope and comprehensiveness of such norms.

OPERATION OF A PSRO

It is expected that a PSRO would operate in a manner which conserves and maximizes the productivity of physician review time without unduly imposing on his principal function, the provision of health care services to his own patients. One way to conserve physician review time is through automated screening of claims by computers and other devices used in the claims process carried out under review specifications and parameters set forth by the PSRO. Another way to conserve physician time would be through the use of other qualified personnel such as registered nurses who could, under the direction and control of PSRO physicians, aid in assuring effective and timely review. And as already pointed out, a third is by utilizing the services of active and conscientious utilization review committees in hospitals and in local medical organizations.

It is expected that the Secretary will develop necessary procedures for coordination between medicaid agencies, medicare carriers and intermediaries and the PSRO's. To the extent that profiles are presently maintained by State agencies, carriers and intermediaries, these would be made available to the PSRO's. Following completion of the conditional period of PSRO designation the Secretary would be authorized to waive any control or review activity required by law which he determines to be unnecessary in view of the review and control activities assumed by and effectively performed by a PSRO. Thus, the PSRO activity would be fitted into the medicare-medicaid process with an eye to efficiency in the system. When a federally financed system of operation of a PSRO is developed, whether directly by the PSRO or by contract, that system would be made available without charge for use by other PSRO's.

Existing medical organizations, such as the San Joaquin and Sacramento Medical Foundations in California, and others have developed patient and practitioner profile forms and approval certification and other review methods which may provide the bases for development of uniform data gathering and review procedures capable of being employed in many areas of the Nation. The committee expects that the Secretary, in conjunction with various medical and other

organizations, would assist the local professional standards review organizations through providing them with model operational guides, forms and methodology descriptions. To the greatest extent possible, standardized forms and procedures should be utilized by the local review organizations. Of course, this approach would not preclude acceptable modification and adaptation to meet local circumstances, but basic formats should be established for national usage and basic comparable data for inter-PSRO comparisons should be developed.

It is expected that where economical and efficient computer and other resources already exist in carriers and intermediaries they would be utilized to the extent feasible and that operations would be consolidated and coordinated wherever possible. In a similar fashion, the PSRO could use the established communication channels of State and local medical associations to keep practicing physicians fully informed of review activities.

The committee would stress that the approach recommended does not envisage Blue Cross or Blue Shield or other insurance organizations or hospital or medical association review committees, assuming the review responsibilities for the professional standards review organizations. Where Blue Cross or Blue Shield or other insurers, or agencies have existing computer capacity capable of producing the necessary patient, practitioner, and provider profiles in accordance with the parameters and other requirements of the PSRO, on an ongoing expeditious and economical basis, it would certainly be appropriate to employ that capacity as a basic tool for the professional standards review organizations; but that mechanism would be employed essentially to feed computer printouts to the review organizations which would be responsible for their evaluation. Where it would facilitate administration, the Secretary could designate a specific carrier or intermediary as "lead" carrier or intermediary for purposes of coordination with PSRO's in an area. The responsibility for handling requests for such prior approval of hospital admissions, elective procedures and services as might be required, as well as the administrative mechanism for processing such requests, would lie with the PSRO's. A "lead" carrier or intermediary would not interfere with nor interrupt direct contact between the Secretary and the PSRO's.

It is expected that PSRO's would make specific arrangements with groups representing substantial numbers of dentists for necessary review of dental services.

PSRO's would be authorized and expected to retain and consult with other types of health care practitioners such as podiatrists to assist in reviewing services which their fellow practitioners provide. However, physicians should not be precluded—in fact they should be encouraged—to participate in the review of services ordered by physicians but rendered by other health care practitioners. For example, physical therapists may be utilized in the review of physical therapy services, but physicians should determine whether the services should have been ordered. The PSRO would be responsible for seeing to it that any arrangement it made was carried out effectively.

Expenses reasonably and necessarily incurred by the PSRO's, statewide councils and advisory groups and the national council would be borne by the Federal Government. Since overutilization of health serv-

ices is not restricted to medicare and medicaid but affects private health insurance as well, the PSRO would be at liberty to provide its review services to private health insurers provided the additional review efforts do not lower the quality of the medicare-medicaid reviews. In such a case, there would be a proportionate allocation of costs between medicare, medicaid, and others served by the review organization.

Employees of the PSRO would be selected by the organization and would not be Government employees. Where the Federal Government has paid for or supplied necessary equipment to the review organizations, title to such property would remain with the Government.

A PSRO agreement would include provision for orderly transfer of medicare and medicaid records, data and other materials developed during the trial period to the Secretary or such successor organization as he might designate in the event of termination of the initial agreement. Such transfer would involve only those records pertinent to medicare and medicaid patients and would be made solely for purposes of permitting orderly continuity of review activities by a successor PSRO.

SANCTIONS AND LIABILITY

It is anticipated that in those areas where PSRO's function effectively, the need for sanctions will be minimal. However, sanctions are provided under the amendment to deter improper activity.

On the basis of its investigations of situations of possible abuse identified in its own review or referred to it by the Secretary or his administrative agents, the PSRO would (after reasonable notice and opportunity for discussion with the practitioner or provider involved) recommend to the Secretary appropriate action against persons responsible for gross or continued overuse of services, for use of services in an unnecessarily costly manner, or for inadequate quality of services and would act to the extent of its authority and influence to correct improper activities.

In determining responsibility for overuse of services, uneconomical use of services or the provision of substandard services, the PSRO would take into account actual ability of the provider or physician to control the activities in question.

Where a review organization finds that voluntary and educational efforts fail to correct or remedy an improper situation with respect to a practitioner or provider, it would transmit its recommendations concerning sanctions through the statewide council to the Secretary of HEW. Protective appeals procedures are afforded to those against whom sanctions have been recommended. Where he receives such a recommendation, the Secretary could terminate or suspend medicare and medicaid payment for the services of the practitioner or provider involved, or assess an amount reasonably related to the excessive costs to the programs deriving from the acts or conduct involved—but not to exceed \$5,000 against persons or institutions found to be at fault. In such cases the practitioner or provider would be granted a hearing by the Secretary on request and could seek judicial review of the final determination of the Secretary.

The amendment provides protection from civil liability for those engaged in required review activities, or who provide information to

PSRO's in good faith, for actions taken in the proper performance of these duties. Activities taken with malice toward a practitioner or institution, or group of practitioners would not be considered action taken in the proper performance of these duties. In addition, physicians and providers would be exempt from civil liability arising from adherence to the recommendations of the review organization (where it was a physician-sponsored and operated PSRO) provided they exercise due care in the performance of their functions. The intention of this provision in the amendment is to remove any inhibition to proper exercise of PSRO functions, or the following by practitioners and providers, of standards and norms recommended by the review organization. Thus, a physician following practices which fall within the scope of those recommended by a PSRO would not be liable, in the absence of negligence in other respects for having done so.

Failure to order or provide care in accordance with the norms employed by the PSRO is not intended to create a legal presumption of liability.

The exemptions from civil liability would apply to a range of patterns which fall within the scope of the norm, to the extent that such a range is considered acceptable by the PSRO in accordance with regulations of the Secretary. For example, the usual length of stay for a given illness might be 6 days, but an individual practitioner might only hospitalize his patient for 4 days. In this case the doctor might be motivated to keep his patient in the hospital for an extra 2 days to assure himself of exemption from liability. However, as described above, the PSRO could approve a range of norms, each of which was considered medically acceptable by the PSRO, which could encompass a hospital stay of 4 days as being sufficient. It is not intended, however, that this protection preclude the liability of any person who is negligent in performing PSRO functions or who misapplies or causes to be misapplied the professional standards promulgated by a review organization.

A physician or provider should not be relieved of responsibility where standards or norms are followed in an inappropriate manner or where an incorrect recommendation by the PSRO is induced through provision of erroneous or incomplete information.

Objective and impartial review must be provided by a PSRO if it is to be effective and respected. Malice, vendettas, or other arbitrary and discriminatory practices or policies are by definition "nonprofessional," and in the unlikely event of such occurrences the Secretary is expected to promptly act to terminate the contract with the organization involved unless it immediately undertakes voluntary corrective measures.

HEARINGS, REVIEW AND WAIVER OF LIABILITY

A medicare beneficiary, medicaid recipient, provider of services or health care practitioner who was dissatisfied with a determination by a PSRO under this provision would be entitled to reconsideration of the determination by the PSRO; where the matter in controversy is \$100 or more the reconsideration would be subject to review, on appeal, by a State Professional Standards Review Council or by the Secretary. Where the amount in question exceeded \$1,000, the Secretary's

final decision would be subject to judicial review. A review or appeal proceeding under the PSRO provision would be in lieu of any other review under the Social Security Act with respect to the same issue.

Generally, where the PSRO disapproved items or services furnished under medicare and medicaid, payment for such items and services could not be made by these programs. However, provision is made for the Secretary to make payment for disapproved items and services where he determined that a claimant was without fault with respect to the provision of items or services. This provision is needed to prevent making individuals liable for payment for the disapproved services when they accepted the services under the impression they would be paid for by medicare or medicaid.

STATE AND NATIONAL ORGANIZATIONS

Under the amendment statewide professional standards review councils (and an advisory group to each council) would be established in States which have three or more PSRO's. A council would consist of one representative from each PSRO, two physicians designated by the State medical society, two physicians designated by the State hospital association, and four persons, knowledgeable in health care, selected by the Secretary as public representatives. Two of the public representatives would be selected from nominees recommended by the Governor of the State.

A statewide council would serve to coordinate the activities of the PSRO's within the State, disseminate information and other data to them and review the overall effectiveness of each of the PSRO's operations. The council would be advised and assisted in its activities by an advisory group consisting of representatives of health care practitioners (other than physicians) and health care institutions.

Completing the structure, a national professional standards review council would be established. That council would consist of 11 physicians of recognized standing and distinction in the review of medical practice who would be appointed by the Secretary. A majority of the members would be selected from nominees of national organizations representing practicing physicians. The council would also include physicians nominated by consumer groups and other health care interests such as hospitals. The national council would arrange for the collection and distribution of data and other information useful to the statewide and local professional standards review organizations; particularly, norms of care employed in various geographic or medical service areas and various methods of utilizing and applying those norms. The national council would also report regularly to the Secretary and to the Congress on the overall and area-by-area effectiveness of the review program and offer such recommendations as it might have for improvement of the program.

ROLE OF THE INSPECTOR GENERAL

Properly established and properly implemented throughout the Nation, professional standards review mechanisms can help relieve the tremendous strain which soaring health costs are placing upon the entire population. Emphasis, wherever possible, upon the provision of

necessary care on an outpatient rather than inpatient basis could operate to reduce need for new construction of costly hospital facilities. Hospital bed need would be further reduced by reductions in lengths of hospital stay and avoidance of admission for unnecessary or avoidable hospitalization.

To be effective, the PSRO provisions will require full and forthright implementation. Equivocation, hesitance, and half-hearted compliance will negate the intended results from delegation, with appropriate public interest safeguards, of primary responsibility for professional review to nongovernmental physicians. For these reasons, the committee expects that the Inspector General for Health Administration (whose office is established under another amendment) will give special attention to monitoring and observing the establishment and operation of the PSRO's to assure conformance and compliance with congressional intent.

Coverage of Certain Maintenance Drugs Under Medicare

(Sec. 215 of the bill)

BACKGROUND

The committee added an amendment to the House bill which would provide coverage of certain maintenance drugs under part A of medicare. Medicare presently covers the cost of drugs given to an inpatient in a hospital or extended care facility, but does not, however, pay for prescription drugs on an outpatient basis.

Beneficiaries and others have frequently indicated the lack of coverage for outpatient drugs as the most significant gap in the medicare benefit structure. Prescription drug expenses account for a large part of the health expenses of older people. More important, perhaps, than the fact that drugs represent a large out-of-pocket expense for the elderly is that this expense is distributed unevenly among the elderly. Those with chronic illnesses such as heart or respiratory diseases are often faced with recurring drug expenses and many of these drugs are critical to the survival of these chronically ill patients. As a result, the elderly with chronic illnesses have, on the average, prescription drug expenditures nearly three times as high as those without chronic illnesses.

The committee believes that an outpatient prescription drug benefit is the most important and logical benefit addition to the Medicare program. However, the committee was quite concerned with the cost and administrative problems associated with proposals to cover all outpatient prescription drugs under medicare. Covering all drugs for the aged and disabled, with a \$1 copayment, was estimated by the Social Security Administration to cost about \$2.6 billion. In addition, the administrative burden of covering all drugs would be enormous since the program would have to deal with millions of small prescriptions, and the utilization controls to assure that prescriptions reimbursed under medicare were reasonable and necessary and used only by beneficiaries, would be quite cumbersome.

In studying the problems posed with respect to establishing an outpatient drugs benefit, the committee concluded that the problems could in large part be surmounted by an approach which focused on provid-

ing specified drugs which are necessary for the treatment of the most common crippling or life-threatening chronic diseases of the elderly. This approach would have four advantages: (1) It would result in the medicare dollar being targeted toward patients with chronic diseases who need drugs on a continuing basis for a lengthy period of time; (2) it would substantially simplify administration of a drugs benefit; (3) it would incorporate almost self-policing utilization controls at a relatively low administrative cost, since the program would involve only a relatively small number of drug entities and the necessity for these drugs would be comparatively easy to establish; and (4) this approach would substantially lower the cost of providing a drugs benefit. The cost of the amendment is estimated at \$740 million for the first full year beginning July 1, 1973.

The committee approach is consistent with the recommendation of the Task Force on Drugs of the Department of Health, Education, and Welfare. The Task Force, in accordance with the Social Security Amendments of 1967, undertook many months of study concerning the appropriateness and possible methods of covering drugs under medicare. In their final report, issued in February 1969, the Task Force stated:

“Available data on drug use by the elderly support the hypothesis that coverage of only those drugs which are important for the treatment of chronic illness among the elderly, and which usually are required on a continuing or recurring basis, would concentrate the protection provided by a drug program where it is most clearly needed.”

After reviewing the relative advantages of this approach, the Task Force recommended:

“In order to achieve maximum benefits with whatever funds may be available, and to give maximum help to those of the elderly whose drug needs are the most burdensome, the Task Force finds that particular consideration should be given to providing coverage at the outset mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness.”

The committee commends the Task Force for its exhaustive and definitive efforts and agrees with its recommendation.

SUMMARY OF COMMITTEE AMENDMENT

Basically, the committee amendment would cover specific drugs necessary for the treatment of the many crippling or life-threatening diseases of the elderly with the beneficiary subject to a copayment of \$1 per prescription.

The chronic illnesses covered under the amendment were carefully chosen. The Task Force on Prescription Drugs issued a voluminous study containing extensive data with respect to drug utilization among the elderly. The table below, taken from the Task Force report, lists the more common chronic illnesses of the elderly, in order of the number of prescriptions related to each condition.

**DESCENDING ORDER FOR NUMBER OF PRESCRIPTIONS USED IN TREATMENT
OF ILLNESSES AMONG THE AGED**

[Excluding mental conditions, gastrointestinal disorders, chronic skin diseases
and anemia]

<i>Diagnosed Conditions</i>	<i>Number of Rx's in thousands</i>
Heart	46,512
High blood pressure.....	19,681
Arthritis and rheumatism.....	17,343
Genito-urinary conditions.....	9,127
Diabetes	8,085
Colds, coughs, throat conditions and influenza ¹	7,504
Other disorders of circulatory system.....	4,776
Injuries and adverse reactions ¹	4,000
Neoplasm	3,701
Eye	3,683
Emphysema	2,766
Asthma and hay fever.....	2,547
Other respiratory conditions.....	2,415
Sinus and bronchial conditions.....	2,138
Ear	2,113
Pneumonia	1,531
Thyroid	1,491

¹ Not included in amendment because of generally short-term nature of condition and need for prescriptions.

The amendment would cover serious chronic conditions necessitating long-term drug treatment with the exception of mental and nervous conditions, chronic skin disease, anemia, and gastrointestinal disorders. These diagnoses are excepted because many of the drugs used in their treatment (for example, tranquilizers, antacids, antispasmodics, antidiarrheals, vitamins, iron, and skin ointments) are drugs which are also used by many people for general reasons and are, therefore, difficult to confine to appropriate usage by beneficiaries only (for example, they could be acquired for use by nonbeneficiaries) as opposed to drugs such as insulin or digitalis which are almost invariably used only by those who have a specific need for them. In addition, concern has been expressed that coverage of the "major" tranquilizers used in the treatment of mental illnesses might encourage over-prescribing of potent tranquilizers for older people.

The amendment would further limit coverage to only certain drugs used in the treatment of covered conditions. In other words, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and other drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs generally used by people without heart conditions. However, other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The provision is designed to establish a basis for coverage of drugs capable of administration at reasonable cost. In this form and scope

it is an approach capable of providing significant help and of allowing for orderly future expansion if that were later decided.

It is expected that the Formulary Committee will study the problems related to the question of possible medicare coverage of drugs used in the treatment of mental illness with particular attention to development of means of assuring appropriate usage of such drugs. The Formulary Committee would submit to the Congress, through the Secretary, a report concerning its findings, conclusions and recommendations with respect to this matter.

ELIGIBILITY

All persons covered under part A of medicare would be eligible for the new outpatient drugs benefit. Under the provision, the drugs covered are necessary in the treatment of the following conditions:

Diabetes	Gout
High blood pressure	Tuberculosis
Chronic cardiovascular disease	Glaucoma
Chronic respiratory disease	Thyroid disease
Chronic kidney disease	Cancer
Arthritis and Rheumatism	Epilepsy
	Parkinsonism
	Myasthenia gravis

The fact that the patient needs the drug would indicate that he suffers from one of the above illnesses. Thus generally the existence of a specific chronic illness would not have to be established in connection with the application for payment for the prescription.

BENEFITS

The covered drug therapeutic categories are as follows:

Andrenocorticoids	Cardiotonics
Anti-anginals	Cholinesterase inhibitors
Anti-arrhythmics	Diuretics
Anti-coagulants	Gout suppressants
Anti-convulsants	Hypoglycemics
(excluding phenobarbital)	Miotics
Anti-hypertensives	Thyroid hormones
Anti-neoplastics	Tuberculostatics
Anti-Parkinsonism agents	
Anti-rheumatics	
Bronchodilators	

Within these categories, eligible drugs would be those prescription drug entities which are included by dosage form and strength in the Medicare Formulary described below. The amendment would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used for a short period of time and drugs such as tranquilizers and sedatives which may be used not only by beneficiaries suffering from serious chronic illnesses, but also by many other persons as well. Beneficiaries would incur a \$1 copayment obligation for each prescription. They would also be

obliged to pay any charges in excess of the product price component of the reasonable allowances where a higher-priced product of a drug included in the Formulary was prescribed and where the allowances were based upon generally available lower cost products (see "reasonable allowance" below). Payment under this program would not be made for drugs supplied to beneficiaries who are inpatients in a hospital or skilled nursing facility because their drugs are already covered under medicare.

FORMULARY COMMITTEE

To assure rational and professional control over the drugs covered and the cost of the drugs benefit, and to assure that funds are being targeted toward the most necessary drug entities within each covered therapeutic category, a Medicare Formulary would be established.

The Formulary would be compiled by a committee consisting of five members, a majority of whom would be physicians. The members would include the Commissioner of Food and Drugs and four individuals of recognized professional standing and distinction in the fields of medicine, pharmacology or pharmacy who are not otherwise employed by the Federal Government and who do not have a direct or indirect financial interest in the economic aspects of the committee's decisions. Members would be appointed by the Secretary for 5-year staggered terms and would not be eligible to serve continuously for more than two terms. The Chairman would be elected by and from the public members for renewable one-year terms.

It is expected that appointees to the Formulary Committee will have the stature and expertise to assure objective effort and informed decision-making of a level engendering public and professional confidence in their integrity and judgment.

The Formulary Committee would be authorized, with the approval of the Secretary, to engage or contract for such reasonable technical assistance as it determined it might need from time to time to enhance its capacity for judgment concerning inclusion of drugs in the Formulary. This could include utilizing the services of the committees and technical staff of the official compendia (the United States Pharmacopeia and the National Formulary). The committee expects that such contracting would be undertaken on a limited ad hoc basis, and will be used to supplement, as necessary, the services available within the Department.

The Formulary Committee's primary responsibility would be to compile, publish, and revise periodically a Medicare Formulary which would contain a listing of the drug entities (and dosage forms and strengths) within the therapeutic categories covered by the program which, based upon its professional judgment, the committee finds necessary for proper patient care, taking into account other drug entities included in the Formulary. To aid fully its consideration as to whether a drug entity should be included in the Formulary, the Formulary Committee would be authorized to obtain any records pertaining to a drug which were available to any other department or agency of the Federal Government and to request of suppliers of drugs and other knowledgeable persons or organizations pertinent information concern-

ing the drug. The committee would be authorized to establish procedures which it might require to determine the appropriateness of including or excluding a given drug from the Formulary.

The Formulary Committee would exercise utmost care in maintaining the confidentiality of any material of a confidential nature made available to it.

For purposes of inclusion in or exclusion from the Formulary of any drug entity (in a given dosage form and strength), the principal factors to be taken into account by the committee would be: (1) Clinical equivalence, in the case of the same dosage forms in the same strength of the same drug entity; and (2) relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category. The price of a drug entity would not be a consideration in the judgment of the Formulary Committee.

In considering which drug entities and strengths, and dosage forms, to include in the Medicare Formulary, the Formulary Committee is expected, on the basis of its professional and scientific analysis of available information, to exclude such drugs as it determines are not necessary for proper patient care taking into account those drugs (or strengths and dosage forms) which are included in the Formulary.

For example, in their consideration of drug entities in the therapeutic category known as anti-anginals, a therapeutic category included in the covered categories, the Formulary Committee would be expected to take into account professional appraisals such as the following which appears in "Drug Evaluations—1971," an authoritative publication of the American Medical Association:

"The effectiveness of the short-acting agents, such as nitroglycerin and amyl nitrite, has been established through many years of use. * * * The oral administration of the so-called 'long-acting nitrates e.g., pentaerythritol tetranitrate, . . . erythrityl tetranitrate, . . . isosorbide-dinitrate, as well as some preparations of nitroglycerin are alleged to reduce the number of episodes and the severity of the pain of angina pectoris. The effectiveness of these agents is even more difficult to determine than that of the short-acting nitrates, and thus the beneficial value of their long-term use is controversial. * * * Thus, it cannot be concluded that the long acting nitrates are of definite therapeutic value for prolonged use.

"Many products are available that contain a mixture of antianginal agents or an antianginal agent with a sedative or other drug(s); however, none of these fixed-dose combinations is rational. There is no evidence that a combination of antianginal agents has any advantage over the individual agents and, if more than one type of drug is needed, they should be prescribed separately."

The above quotation is illustrative of the type of source and information to which the Formulary Committee is anticipated to give serious consideration and weight in determining those drug entities (and dosage forms and strengths) which are reasonably appropriate as eligible drugs for purposes of medicare reimbursement.

Prior to removing any drug entity (or a particular dosage form or strength) from the Formulary, the committee would afford reasonable opportunity for a hearing on the matter to persons engaged in manufacturing or supplying the drug involved. Similarly, any person manufacturing or supplying a drug entity not included in the Formulary, but which he believed to possess the requisite qualities for inclusion, could petition the committee for consideration of the inclusion of his drug and, if the petition was denied, might, at the discretion of the committee, upon reasonable showing to the Formulary Committee of ground for a hearing, be afforded a hearing on the matter.

In addition to the list of drug entities included in the Formulary, the Formulary would also include a listing of the prices (generally the average wholesale prices) at which the various products of the drug entities are usually sold by suppliers to establishments dispensing drugs.

The Formulary Committee would be solely responsible for professional judgment as to which drug entities (and dosage forms or strengths) are included in the Formulary. The Secretary would not be involved in the making of those professional determinations.

REIMBURSEMENT

Reimbursement would be based, generally, on the average wholesale price at which the prescribed product of the drug entity included in the Formulary is sold to pharmacies plus a professional fee or other dispensing charges, except that reimbursement could not exceed an amount which, when added to the copayment required of the beneficiary, exceeded the actual customary charge at which the dispenser sells the prescription to the general public.

Both components of the reimbursement would be subject to overall limitations just as medicare's reimbursement to physicians, hospitals and other suppliers is subject to overall limitations. The professional fee or other dispensing charge would not be recognized for medicare reimbursement purposes to the extent that it was in excess of the 75th percentile of fees or charges for other pharmacies in the same census region. In establishing the 75th percentile limit in an area where some pharmacies use one system of calculation and others use a different system, it is the intent that the 75th percentile of charges be calculated independently for the two systems only where a substantial number of pharmacists in an area used each of the methods of charging for dispensing costs. Otherwise, use of the percentile would have the result that a scattering of pharmacists using a given form could set their own limit which might not be reasonable in relation to the usual practices in a community. In order to avoid this undesirable effect, where only a few pharmacists in an area used a given form of dispensing charge, the limit on this charge would normally be set at a level essentially equivalent to the 75th percentile for the form of dispensing charge most frequently used by pharmacists in an area. In determining the 75th percentile, pharmacies with a lesser volume of prescription business would be compared with each other and all larger volume pharmacies would be similarly compared with each other.

Increases in the prevailing professional fees or other dispensing charges would be recognized in a manner similar to recognition of

increases in prevailing physicians' fees. That is to say, increases in prevailing fees or dispensing charges could be recognized (not more than annually) up to limits established for program purposes by factors based upon changes in costs of doing business and average earnings levels in an area during a given period of time. A given pharmacy could change from a professional fee to another dispensing charge basis or vice versa, but for program reimbursement purposes the net effect of such change should be neutral.

Program payment for the drug entity (in given dosage forms and strengths) would be limited to reasonable allowances determined by the Secretary on the basis of the average wholesale prices at which the various products of the drug entity (in a given dosage form and strength) are commonly sold to pharmacies in a region plus the professional fee or dispensing charge. The beneficiary would be obligated to pay \$1 of the reasonable allowance. If there was only one supplier of a drug entity, the price at which it was generally sold (plus the fee or dispensing charge) would represent the reasonable allowance. If, however, several products of the drug (in the same strength and dosage form) were generally available, reasonable allowances would be established which would encompass the lower priced products which were generally available and sold to pharmacies in a region. The number of lower priced products selected would stop at the point where reasonable availability of the drug entity is assured. In the latter case, other products of the drug entity (in the covered dosage form and strength) could also be reimbursable—even though not specifically included in the range of lower-priced products—where the average wholesale price of any such product was at or below the point used by the Secretary in establishing a reasonable allowance. This procedure avoids the problem of having to list every eligible drug product falling within the range of acceptable supplier prices in order for it to be reimbursable.

Products of a drug entity included in the Formulary which are priced above the highest reasonable allowance would be reimbursable but only to the extent of the highest reasonable allowance. The beneficiary would be obligated to pay the excess cost.

There would be three circumstances under which the program payment for a prescription could exceed reasonable allowances. First, if the supplier of a given drug product (of a drug entity in a strength and dosage form included in the Formulary) can demonstrate to the Formulary Committee that his product possesses distinct therapeutic advantages over other products (of the same dosage form and strength) of that drug entity, then the reasonable allowance for that drug product would be based upon the price at which it was generally sold to pharmacies. Second, where the Formulary Committee believed there was legitimate question concerning the clinical equivalency of the various products of different suppliers of a covered drug entity (or of given dosage forms and strengths) the Formulary Committee would be expected to list all of the products of the covered drug entity (in the dosage forms and strengths in question) so as to provide the prescriber with complete discretion until such time as the matter was resolved. Thus, the reasonable allowance would be based upon the reasonable customary price to the pharmacy for the product prescribed by

the physician in such cases. Third, if the physician felt in a specific instance that a particular manufacturer's product of a drug entity included in the Formulary, but which was priced above the highest product price component of the reasonable allowance, provides superior therapy to his patient and if he prescribes that product in his own handwriting by its established name and the name of its supplier, the reasonable allowance for the product would be based upon the price at which it was generally sold to pharmacies. Thus, a physician's reasonable discretion to prescribe a particular product of a drug entity included in the Formulary would be accommodated. In such cases, however, the reasonable allowance would not be greater than the actual usual or customary charge at which the pharmacy sells that particular drug product to the general public. The committee expects that these unusual prescribing situations will occur in only a small percent of cases, and this procedure would not negate the overall medicare requirement that services be reasonable and necessary. The Professional Standards Review Organizations (or, in the absence of a PSRO, other appropriate professional review), would be available to routinely review prescribing practices.

In circumstances other than those described above, where the cost of the drug product prescribed by the physician exceeds the highest product price component of the reasonable allowance, the beneficiary would be liable for charges to the extent of this excess including any related dispensing fee or charge.

Ordinarily, however, the beneficiary's obligation would be \$1 per prescription, with the program paying the balance to the pharmacy.

Reimbursement to providers participating under medicare for other than the drugs program (such as hospitals) would be made on the regular reasonable costs basis.

In the case of insulin, reimbursement would be made to a pharmacy for its reasonable, usual and customary charge to the general public, plus a reasonable billing allowance less the \$1 copayment.

Reimbursement would generally be made only to participating pharmacies. The exception would be that payment may be made for covered drugs dispensed by a physician where the Secretary determines that the drug was required in an emergency or that no pharmacy was reasonably available in the area.

PARTICIPATING PHARMACIES

As mentioned above, reimbursement under this program would be limited to participating pharmacies. No program reimbursement would be made either to the beneficiary or to a pharmacy where the prescription was dispensed by a non-participating pharmacy. The use of participating pharmacies would substantially decrease the administrative costs of the program, as participating pharmacies would generally submit batches of prescriptions and the program would not need to reimburse individual beneficiaries on a prohibitively costly prescription-by-prescription basis.

Such pharmacies would have to be licensed (where required) in the State in which they operate and would have to meet conditions of participation established by the Secretary of Health, Education, and Welfare. Participating pharmacies would file with the Secretary

a statement of their professional fee or dispensing charges (including minimum charges) as of June 1, 1972, so that the Secretary could determine the initial prevailing fee or charges in the census region for purposes of calculating reasonable allowances.

Participating pharmacies would agree to accept medicare reimbursement as payment in full and would further agree not to charge the beneficiary more than \$1 copayment (except to the extent that a product prescribed by a physician was one whose cost exceeded the reasonable allowance).

The participating pharmacy would be paid directly by medicare on a prompt and timely basis with respect to eligible prescriptions submitted. The prescriptions from each pharmacy would be audited from time to time, on a sample basis to assure compliance with program requirements.

ADMINISTRATION

The committee amendment has been structured in such a way as to simplify and facilitate provision of and payment for benefits.

However, the committee has chosen not to specify a particular method or mold of administration. Because this is a new benefit, it is difficult to forecast which methods or organizational structures might most suitably implement the committee's intent that the drugs benefit be administered in the most efficient, expeditious and economical fashion. Fulfillment of the committee's intent would not necessarily entail uniform organization and procedures in each region. The Secretary could find that different means of administration in different regions or areas were appropriate in achieving the administrative objectives of the committee.

Inspector General for Health Administration

(Sec. 216 of the bill)

Based upon its years of inquiry and extensive examination of the medicare and medicaid programs, the committee found that these programs have suffered from the lack of a dynamic and ongoing mechanism with specific responsibility for continuing review of medicare and medicaid in terms of the effectiveness of program operations and compliance with congressional intent.

While the Comptroller General and the Department of Health, Education, and Welfare's Audit Agency have done some valuable and helpful work along the above lines, there is a pronounced need for vigorous day-to-day and month-to-month monitoring of these programs, conducted by a unit relatively free of constant pressures from various nonpublic interests at a level which can promptly call the attention of the Secretary and the Congress to important problems and which is charged with authority to remedy such problems in timely, effective, and fully responsible fashion.

To achieve the above objectives, the committee has approved an amendment which would establish an Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare. The amendment is similar to the amendment approved by

the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The responsibilities and role envisaged for the Inspector General for Health Administration are essentially patterned after the successful approach employed in the Agency for International Development and the investigative and reporting responsibilities, with respect to congressional requests, required of the U.S. Tariff Commission.

The Inspector General would be provided with authority sufficient to assure that medicare and medicaid function as Congress intends.

He would be appointed or reappointed by the President with the consent of the Senate for a term of 6 years. A Deputy Inspector General and such additional personnel as are necessary to carry out the functions of the Inspector General's office are also authorized.

The Inspector General is to report directly to the Secretary of HEW and in carrying out his responsibilities he is not to be under the control of, or subject to supervision by, any officer of HEW other than the Secretary.

The Inspector General will have the duty and responsibility of arranging, conducting, or directing reviews, investigations, inspections, and audits of medicare, medicaid, and any other programs of health care established under the Social Security Act as he considers necessary for determining—

- (a) Efficiency and economy of administration;
- (b) Consonance with provisions of law; and
- (c) The attainment of the objectives and purposes for which the provisions of law were enacted.

He will be required to maintain continuous observation and review of the programs to determine the extent to which they comply with applicable laws and regulations and to evaluate the extent to which the programs attain the legislative objectives and purposes. The Inspector General is to make recommendations for correction of deficiencies or for improving the organization, plans, procedures, or administration of the health care programs.

In carrying out his duties, the Inspector General will have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which relate to the health care programs. The head of any Federal department, agency, bureau, office, et cetera, and the head of any State agency administering an approved medicaid plan would also, upon his request, provide any information which the Inspector General determines would assist in the carrying out of his responsibilities.

The Inspector General will have authority to suspend (upon at least 30 days' notice to the Secretary) any regulation, practice, or procedure employed in the administration of any of the health care programs if he determines (as a result of any study, investigation, review, or audit) that the suspension will promote efficiency and economy in the administration of the program, or that the regulation, practice, or procedure involved is contrary to or does not carry out the objectives and purposes of applicable provisions of law. Any suspension would remain in effect until an order of reinstatement was issued by the Inspector General except that the Secretary might, at any time prior to or after any such

suspension by the Inspector General, issue an order revoking the suspension.

When the Inspector General issued any order of suspension or reinstatement, he would promptly notify the Committee on Ways and Means of the House of Representatives, the Committee on Finance of the Senate and, in the case of an order relating to a State medicaid plan, the Governor or other chief executive officer of the State, of the order, and submit to them information explaining the reasons for suspension or lifting of suspension. Where the Secretary terminates an order of suspension issued by the Inspector General, he is required also to submit an explanation of his reasons to the two committees.

Where the Inspector General issues an order suspending any State regulation, practice, or procedure regarding its approved medicaid plan, and the State fails to comply with the order, the amount of Federal medicaid payment due the State during the period it so fails to comply will be reduced by an amount equal to the excess of the Federal medicaid funds payable to the State during the period it so fails to comply over the amount of Federal funds payable to the State if it had complied with the order.

The Inspector General could submit to the Committees on Ways and Means and Finance such reports relating to his activities as he deemed appropriate. He would, upon the request of either committee for any information, study, or investigation relating to, or within his responsibilities, cause such information to be furnished and such study or investigation to be undertaken.

This new office, with lines of communication direct to the Secretary of the Department and to the concerned committees of Congress, will make a major—and badly needed—contribution to the efficiency of the massive Federal health programs reflected in the medicare and medicaid statutes.

Expenses of the Inspector General are authorized in such amounts as are necessary to carry out the purposes of the amendment with the Secretary of HEW allocating proportions of the total amount to the various health care programs and trust funds involved.

The Inspector General may make confidential expenditures of up to \$50,000 in any fiscal year, except that not more than \$2,000 may ever be paid with respect to any one individual. He would submit an annual confidential report of any such expenditures to the Committee on Finance and to the Committee on Ways and Means.

Medicaid Coverage of Mentally Ill Children

(Sec. 299B of the bill)

Under present medicaid law, reimbursement for inpatient care of individuals in institutions for mental diseases is limited to those otherwise eligible individuals who are 65 years of age or older.

Matching for outpatient care for mentally ill children, as well as needy adults, is currently available under title XIX. The committee supports use of these funds where appropriate, and believes that outpatient treatment in the patient's own community should be used wher-

ever possible. However, in some cases, inpatient care in an institution for mental diseases is necessary.

The committee amendment would therefore authorize Federal matching under medicaid for eligible children, age 21 or under, receiving active care and treatment for mental diseases in an accredited medical institution. The definitions of active care and treatment in accredited mental institutions are those applicable to psychiatric institutional care under the medicare program. An appropriate "maintenance of effort" provision is included to assure that the new Federal dollars are utilized to improve and expand treatment of mentally-ill children.

The committee believes that the nation cannot make a more compassionate or better investment in medicaid than this effort to restore mentally ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens.

The committee also believes that the potential social and economic benefits of extending medicaid inpatient mental hospital coverage to mentally ill persons between the ages of 21 and 65 deserves to be evaluated and has therefore authorized demonstration projects for this purpose.

The amendment is effective January 1, 1973.

Uniform Standards for Skilled Nursing Facilities Under Medicare and Medicaid

(Sec. 246 of the bill)

Under current law, skilled nursing facilities wishing to participate in both the medicare and medicaid programs are subject to similar conditions of participation although there are differences in the way regulations governing participation in the two programs are interpreted and applied from State to State.

While the emphasis of the care in skilled nursing facilities covered under the two programs differs somewhat—medicare focusing on the short-term care patient and medicaid on the long-term care patient—patients in these facilities intended to be covered under both plans require the availability of essentially the same types of services and are often in the same institution. Indeed, not infrequently, after expiration of medicare benefits, the patient may remain in the same facility—even in the same room—continuing on as a medicaid recipient.

Because of the substantial similarities in the services required of skilled nursing facilities under the two programs, the existence of separate requirements (which may differ only slightly) and separate certification processes for determining institutional eligibility to participate in either program is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved to provide care under both medicare and medicaid. The committee believes therefore that it would be desirable to apply a single set of requirements to skilled nursing facilities under both medicare and medicaid.

The committee amendment provides for a single definition (skilled nursing facility) and a single set of requirements for the skilled nursing home and the extended care facility. The definition would incorporate the best features of the medicaid and medicare requirements. The amendment would further provide that facilities which satisfy the new definition of "skilled nursing facility" under one program shall be eligible to participate in the other provided it agreed to contract terms. The amendment would incorporate the present medicare definition and requirements for an extended care facility and would add the following three requirements:

(a) That it supply full and complete information as to the identity of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility; in case a facility is organized as a corporation, of each officer and director of the corporation; and in case a facility is organized as a partnership, of each partner; and promptly report any change which would affect the current accuracy of the information so required to be supplied;

(b) That it cooperate in an effective program of independent medical evaluation and audit of the patients in the facility;

(c) That it meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing facility, but only if such waiver will not adversely affect the health and safety of the patients.

A single consolidated survey would be performed at least every 12 months to determine a facility's qualifications for both medicare and medicaid.

The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities. As at present, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. Where a State imposes additional requirements in its own right, then, as under the present section 1863, those standards would apply to both medicare and medicaid skilled nursing facilities in the State.

This amendment incorporates the general thrust of an amendment previously developed by the committee and included in H.R. 17550.

The amendment is effective July 1, 1973.

Definition of Care in Skilled Nursing Facilities

(Sec. 247 of the bill)

The committee bill contains a provision which would conform the definition and the participation standards for skilled nursing facilities under medicare and medicaid. A common definition-of-care requirement under medicare and medicaid to assure that the benefits are payable on behalf of those types of patients who can best utilize the

skilled types of services available in such institutions would be consistent with the role these skilled nursing facilities should play in medical care.

The committee bill would establish a single common definition of care requirements for extended care services under medicare and skilled nursing services under medicaid as follows: Services provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

Skilled nursing services include: assessment of the total needs of the patient, planning and management of a patient care plan, observation and monitoring of the patient's responses to care and treatment, and rendering or supervising the rendering of direct services to the patient where the ability to provide the services or supervise the provision of the services requires specialized training.

Services such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered and which does not require the continuing attention of trained paramedical personnel, would not be included as skilled nursing services. Of course, if a patient needed a variety of unskilled services on a regular daily basis, that patient could, nonetheless, be considered a skilled care patient if the planning and overseeing of the aggregate of the unskilled services required regular daily involvement of skilled personnel.

Some examples of services which meet the definition of skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services.)
- Levine tube and gastrostomy feedings.
- Naso-pharyngeal and tracheotomy aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescription medications and aseptic techniques.
- Care of extensive decubitus ulcers and other widespread skin disorders.
- Initial phases of a regimen involving administration of medical gases.
- Restorative nursing procedures, including the related teaching and adaptive aspects of skilled nursing, which are part of active treatment and require the presence of licensed nurses at the time of performance, e.g., teaching the skills and facts necessary for understanding adherence to a regimen such as bowel and bladder training.

Both the availability of alternative health care facilities and services and the patient's condition would be taken into account in determining whether his need for care or supervision justifies the utilization of a skilled nursing facility rather than a more economical alternative. (In other words, if, in the case of medicaid, there were no intermediate

care facility beds available, placement in a skilled nursing facility might be appropriate for a patient who did not need skilled services as defined above although, in such cases, reimbursement to the facility should be at a reduced rate commensurate with the services provided.)

The types of services which would be covered under both medicare and medicaid would include those skilled services which are essential to the rehabilitation and recovery of the patient, and also those which are necessary to prevent deterioration of the patient's condition and sustain the patient's current capacities even when full recovery or medical improvement is not imminent.

Since the principal aspect of covered care relates to the skilled services being rendered, the restorative potential of the patient is not controlling. Many patients who have no potential for rehabilitation require a level of care which is covered under the program. For example, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is receiving care covered by this definition. Thus, the controlling factor in determining whether a person is receiving covered care is the skill and frequency involved and the supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

In the case of medicare, the services must be a continuation of treatment of a condition for which the beneficiary received hospital services in the period immediately before his admission to the skilled nursing facility.

It has come to the committee's attention that the application of the definition of the extended care level of services can result in denial of medicare payment for services received in skilled nursing facilities by patients who are in regular need of skilled rehabilitation services (other than nursing) which are essential to their recovery from an in-hospital stay or to prevent their condition from worsening and which as a practical matter should be provided in an institution. Often, transporting a patient from his home to a place where he may receive the needed rehabilitation is an excessive physical hardship on ill patients and uneconomical, especially when the patient requires ambulance transportation.

The recognition of a patient's need for skilled rehabilitative services as a basis for meeting the level of care requirement is intended to cover situations such as the following: (1) non-ambulatory stroke patients who need daily skilled rehabilitative services such as speech therapy, but who do not necessarily need skilled nursing services; and (2) hip fracture patients who need daily physical therapy services after the fracture has healed to the weight-bearing stage.

These kinds of services, however, would be covered only if they can as a practical matter be provided only in the skilled nursing facility setting because other arrangements that could be made to provide the needed services (e.g., bringing the services to the patient in his place of residence or daily transportation to an outpatient facility) are not practical because of the patient's condition or from the standpoint of efficient delivery of the required services. In determining whether other arrangements would be practical, the coverage or

noncoverage of the various alternatives under medicare or medicaid should not be taken into account—the issue is feasibility and not whether coverage is provided in one setting and not provided in another.

In some cases a skilled nursing facility may have patients who require only intermediate care rather than daily services which must be provided by or under the supervision of skilled personnel. When regular skilled care is not required, medicare would make no payment unless the care was received during a posthospital stay in which skilled services were normally required and provided there was only a day or two on which no skilled services were provided but discharge from the skilled nursing facility was not practical. Under medicaid, intermediate care is usually covered and would be paid for at an amount commensurate with the level of service required and provided, not at the amount paid for skilled care. However, a State could, with respect to those patients needing skilled care, as defined herein, reasonably classify such patients (for reimbursement or other appropriate purposes) so as to distinguish between those who require a greater or lesser range or quantity of skilled services or supervision.

The committee expects that the Professional Standards Review Organizations (established under another provision of the committee's bill) would provide scrutiny over whether appropriate patient placement was being made and that the Inspector General (also established under this bill) would also observe the operation of the provision.

The committee recognizes that the modified definition of care which would be reimbursable in skilled nursing facilities may have a substantial impact on extended care benefit costs. The Department of Health, Education, and Welfare has estimated that the cost of extended care benefits in skilled nursing facilities under medicare may increase some \$90 million during the first full year of operation. However, the committee believes that to some extent these costs would be offset by reduced expenditures for hospital care and reduced medicaid expenditures. Under medicaid, the impact of the change will vary among the States, but to some degree it should have the effect of stimulating the removal of patients requiring only intermediate care or the reclassification of such patients in skilled nursing facilities which also provide intermediate care.

The amendment would become effective with respect to services furnished on and after January 1, 1973.

Authorization for the Secretary to Determine Whether a Facility Is Qualified to Participate as a "Skilled Nursing Facility" in Both Medicare and Medicaid

(Sec. 249A of the bill)

At present, the decision as to whether a skilled nursing home is qualified to participate in the medicaid program is ultimately determined by each State medical assistance agency (the title XIX agency). The facility makes application to the State medical assistance agency which in turn makes the arrangements for a survey of the facility by the surveying agency (generally the State health agency).

The title XIX agency reviews the survey findings and makes the final decision regarding the facility's qualifications for participation.

Unlike medicaid facilities, facilities participating in the medicare program are subject to a certification process which reduces—but does not totally avoid—State to State variability. The Secretary of Health, Education, and Welfare, acting through the appropriate Regional Office staff of the Social Security Administration, arranges for the State health agency to survey the facility desiring to participate under medicare and uses the results of the survey to make the final determination on certification of the facility.

Facilities certified to participate under both medicare and medicaid may be subject to differences in application of requirements inherent in the different certification operations of each program. The committee believes that present State certification of skilled nursing facilities has certain disadvantages, including lack of uniformity in application of standards to which all facilities are subject and duplication of certification efforts by State and Federal Governments. In addition, development of common standards for skilled nursing homes and extended care facilities as skilled nursing facilities, approved by the committee in another section of this bill, makes separate certification procedures unnecessary.

The committee's amendment provides, therefore, that determination of basic eligibility of skilled nursing home under title XIX be made by the Secretary. The appropriate State health agency would survey facilities wishing to participate in either (or both) the medicare or medicaid programs and report its findings and recommendations to the Secretary. The Secretary would make a determination as to eligibility and advise the State if a facility meets the basic requirements for participation as a skilled nursing facility.

A State could for good cause decline to accept as a participant in the medicaid program a facility certified by the Secretary. Good cause, for example, could include non-usage of a facility because an area is "overbedded" as determined by an areawide facilities plan or because the rates charged were out-of-line.

A State could not receive Federal matching funds for services provided by any facility not approved by the Secretary.

In applying uniform certification standards for skilled nursing facilities, the test will be whether the facility is in full compliance with all certification requirements. The State's judgment as to whether a facility is in full compliance with a requirement will be subject to the Secretary's review and approval. If it is determined that a facility is not in full compliance with one or more requirements (which do not jeopardize the health or safety of patients) reasonable time will be permitted for correction of deficiencies. Use of provider agreements without fixed expiration dates would not be continued because this procedure has in the past caused serious difficulties and delays in decertifying a facility with deficiencies. Therefore, a facility will be issued time-limited provider agreements of up to twelve-months duration. But in no case longer than the period allowed for correction of deficiencies as determined by the Secretary.

The Department would be provided with sufficient flexibility in applying this procedure in its initial year of implementation to estab-

lish a staggered schedule of surveys and expiration of contracts to avoid "peaking" of workloads. It would be expected that surveys would ordinarily be scheduled at least 60 days before the expiration of the contract.

Review and certification of intermediate care facilities would remain a State responsibility.

This amendment would be effective July 1, 1973.

Requirements for States Participating in Medicaid To Pay Skilled Nursing and Intermediate Care Facilities on a Reasonable Cost-Related Basis

(Sec. 249 of the bill)

Under the medicare program extended care facilities are reimbursed for the reasonable costs they incur in providing covered services plus, in the case of proprietary institutions, an allowance related to net capital equity. Under medicaid States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities. States generally establish (in advance) per diem or similar basic rates payable for patients receiving skilled nursing facility and ICF care. Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive.

On the other hand the reasonable cost reimbursement approach of the medicare program has in many cases created difficulties for extended care facilities. The detailed and expensive cost-finding requirements can prove cumbersome.

The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis by July 1, 1974. This approach is preferable to the arbitrary rate-setting currently in effect in some States which provide no incentive to facilities to upgrade the level of care provided. The States would use acceptable cost-finding techniques (not necessarily those utilized for medicare purposes) to determine reasonable reimbursement and apply to the results appropriate methodologies for determining payment. The methods would have to be approved and validated by the Secretary. The committee does not intend that this provision should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, although States are free to choose this option. Rather, the States could develop other reasonable cost-related methods of rate-setting. Whatever methodology is authorized should include adequate procedures for auditing, as necessary, the financial records of an institution. States would not be required to reimburse for luxury services, questionable allowances for depreciation and similar items which they might reasonably choose not to recognize as "reasonable." States would be free to provide for retroactive adjustments of rates or costs to the extent necessary to prevent "windfalls" or unjustifiably low payment. The Secretary would be expected to validate, on site, a State's methodology through sample audits. Reasonable cost-related rates could be determined on a

geographic basis, a class basis, or on an institution-by-institution basis.

The committee amendment provides that cost reimbursement methods which the Secretary would find acceptable for a State's medicaid program would also be adapted, with appropriate adjustments, in the State for purposes of medicare reimbursement. The Secretary would be permitted to adjust a rate upward where appropriate, to reimburse for specific factors related to medicare requirements (such as keeping a reasonable number of beds available, type of occupancy covered, any additional administrative costs) which are not considered by the State or included in the computation of its medicaid rates. Such adjustments would be distilled into a percentage factor (not in excess of ten percent) so as to simplify reimbursement. These percentage adjustments may be made on a geographic basis of classes of facilities and not necessarily on an institution-by-institution basis. A similar provision was included in H.R. 17550.

Where a skilled nursing facility is a distinct part of, or directly operated by a hospital, reimbursement would be made for care in such facilities in the same manner as is applicable to the hospital's costs. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital (which would be defined in regulations of the Secretary) reimbursement would be made on the basis of costs not to exceed 150 percent of the adjusted medicaid rate of payment (if the Secretary applies such rates to medicare facilities in that State) for care in that facility (or comparable facility).

This approach avoids substantial auditing and cost-finding expense and provides a means of making equitable adjustments where appropriate.

Public Disclosure of Information Concerning Required Survey Reports of an Institution

(Sec. 299D of the bill)

At present, information as to whether a hospital, skilled nursing facility, or other organization fully meets the statutory and regulatory requirements relating to conditions for participation for medicare and medicaid or whether it has significant deficiencies, is generally available only to the facility involved, and certain State and Federal agencies. Physicians and the public, in general, are currently unaware as to which institutions have significant deficiencies and which do not. The committee believes that in the absence of public knowledge about the nature and extent of deficiencies of individual facilities, it is difficult for physicians and the public to rationally choose among health care facilities and to effectively direct their concern about short-comings to the deficient facilities and to bring pressures for improvement to bear on those facilities.

The committee believes that ready public access to timely information about the existence or absence of deficiencies (such as in areas of staffing, sanitation, fire and other safety requirements) would help substantially in encouraging facilities to correct their deficiencies and, at the same time, enable physicians and patients to make sound judg-

ments about their own use of available facilities in the community. Given the necessary information, the community should be able to exert greater influence on institutions to assure that they develop and maintain high standards of care.

The committee bill, therefore, requires the Secretary of Health, Education, and Welfare, following completion of a survey of a health care facility or organization, to identify and make available to the public information from the survey on the absence or presence of deficiencies in every significant area relating to requirements in titles XVIII and XIX and related regulations. Significant areas would include all statutory requirements such as those relating to nursing personnel, as well as other requirements the Secretary establishes by regulation for the health and safety of patients.

Information on the significant survey findings relative to individual institutions and other organizations identified in the course of a survey, would be available for public inspection in readily accessible form and fashion in Social Security district offices and local welfare offices upon request within 90 days of completion of a survey.

This provision is similar to the provision developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The provision is effective beginning with surveys completed after the sixth month following the month of enactment.

Validation of Services Made by the Joint Commission on the Accreditation of Hospitals in Medicare

(Sec. 244 of the bill)

Under present law an institution is deemed to meet the certification requirements of medicare (except for utilization review requirements) if such an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals (JCAH).

In addition, the law states, under the definition of a hospital, that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. However, if a State sets higher standards for institutions within its jurisdiction for medicaid, these requirements are also used for medicare.

The JCAH, which consists of representatives of the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians, has been surveying hospitals which voluntarily request accreditation since 1952. Two-thirds of the hospitals, including almost all large hospitals certified to participate in medicare, received such certification as a result of JCAH accreditation. Of over 6,700 hospitals approved to participate in medicare, about 4,500 have been certified on the basis of JCAH accreditation. About 2,300 additional facilities were certified by the Social Security Administration, following surveys performed by State health facility licensure agencies, as meeting statutory requirements and standards established by the Public Health Service.

Initially, the conditions of participation were linked to those of the JCAH to provide assurance to those who were concerned, prior to the enactment of medicare, that only professionally established conditions would have to be met by providers of health services who wished to participate in the medicare program as well as providing for use of a certification program which was operational before medicare. However, the committee has since found several areas of concern with respect to the JCAH role in the medicare certification process.

The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to JCAH, itself, and the concerned facility. These elements prevailed, however, prior to medicare's enactment and were understood at the time of enactment of the program. No inference should be drawn that hospitals and the JCAH changed the "rules of the game" in any way. However, since JCAH survey reports are not available to the Government, the Federal agencies responsible to the Congress for the administration of medicare are not in a position to audit the validity of the overall JCAH survey process, and thus the Government is unable to determine the extent to which serious deficiencies may exist in these participating hospitals.

A further potential difficulty arises because, under present law, medicare cannot set standards which are higher than comparable JCAH requirements. This has been interpreted by the Social Security Administration to bar establishment of any standards in any area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves to provide an almost blanket delegation of authority over hospital standards to a private agency. Thus theoretically, if the Joint Commission chose to lower a standard, medicare would also be required to accept that reduced standard. Though the Federal Government is limited to JCAH standards, a State may promulgate higher standards for facilities within the State for State programs. Licensure requirements, of course, apply to all facilities.

The committee added to the House bill a provision developed with the complete cooperation of the Joint Commission, which would authorize the Secretary to enter into an agreement with any State under which the appropriate State or local certifying agency would survey JCAH-accredited hospitals on a selective and limited sample basis, or where the Secretary finds in the case of a given institution that a survey, or more limited investigation, is appropriate because he has received a substantial allegation with evidence, or believed to have substance, of the existence of a condition significantly adverse to the health or safety of patients. The Secretary is expected to establish procedures for orderly and timely submission and transmittal of any such allegations. Such a condition would exist when there is a lack of conformity with a standard or critical factor of medicare conditions of participation which would, under procedures applicable to nonaccredited hospitals, constitute a deficiency or deficiencies of such character as to seriously limit the capacity of the institution to render adequate care and to require State agency survey and followup action.

One or more Federal members could be added to a State team which has been assigned to survey an accredited hospital, to the extent that

the Secretary found it desirable in the interest of maintaining uniformity of results in carrying out sample studies, or to augment a survey team's capability. These sample and special surveys would serve as a mechanism to validate the JCAH survey process. If in the course of such a survey an institution were found to have significant deficiencies, following timely discussion of such deficiencies with JCAH the detailed medicare standards and compliance procedures would be applied in place of the general JCAH standard.

The requirements of this provision have been discussed with the JCAH and are generally acceptable to it as reasonable. The JCAH has offered its full cooperation and it is expected that the Joint Commission will be fully and continually consulted and involved (on a reimbursable basis, where appropriate) in the implementation of this provision. To implement the sample surveys and to follow up effectively on any deficiencies found the amendment provides that JCAH-accredited hospitals would have to agree, in order to qualify for reimbursement under medicare and medicaid, to authorize JCAH to furnish the Secretary and State health agencies, on a confidential basis, with copies of the JCAH survey report, when and if the hospital was to be surveyed. (Significant deficiencies found in medicare-medicoid surveys of accredited hospitals authorized under this provision would be subject to public disclosure under another provision of this bill.)

The Secretary would be authorized, after consultation with the JCAH, to promulgate standards, as necessary for health and safety, which may be higher or more precise than those of the JCAH and which all hospitals would have to meet after appropriate and adequate time for compliance. It is expected that this provision would seldom be used because, if a worthwhile improvement in accreditation requirements were identified by the Secretary, it would, in all probability, be adopted by the JCAH. If the JCAH, as a condition for accreditation of a hospital, requires a utilization review plan, or a substantially equivalent requirement, or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by him, the Secretary may find that all institutions so accredited by the JCAH comply with medicare standards.

The purpose of the committee amendment is to provide a mechanism for reasonable continuing validation of the voluntary accreditation process and not to duplicate that process. The Secretary would also be required to include in his Annual Report to the Congress on medicare an evaluation of the JCAH accreditation process as indicated by the survey process.

Medicare Coverage for Certain Individuals Aged 60-64

(Sec. 214 of the bill)

Present law provides hospital insurance protection for persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs. Essentially, all persons aged 65 and over are eligible to enroll for medical insurance (part B) without regard to insured status. The committee has approved a provision in the House bill which would permit persons

aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A at a premium rate equal to the cost of their protection.

The committee is concerned that many social security and railroad retirement cash beneficiaries aged 60-64 and spouses aged 60-64 of medicare beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. Frequently these older persons—retired workers, wives, husbands, widows, widowers, mothers, parents, brothers and sisters, for example—have been dependent for health insurance protection on their own group coverage or that of a related worker who is now retired or deceased. It is a difficult task for such older persons to secure comparable protection at affordable cost when they are not connected with the labor force.

The committee, therefore, has added to the House bill a provision which would make medicare protection (both part A and part B) available on an optional basis at cost to spouses aged 60-64 of medicare beneficiaries; others aged 60-64 who are entitled to retirement, wife's, husband's, widow's, widower's, mother's, parent's, or brother's and sister's benefits under social security and the railroad retirement programs; and disability beneficiaries aged 60-64 not otherwise eligible for medicare because they have not been entitled to cash disability benefits for 24 months. The availability of medicare protection would be limited to persons aged 60-64 because the committee believes that people under age 60 who are not disabled generally have relatively little difficulty in obtaining private health insurance. About 6 million persons aged 60-64 would be potentially eligible to enroll for medicare as spouses of medicare beneficiaries or as beneficiaries entitled to the benefits specified above.

Persons who elect to avail themselves of medicare protection under this provision would pay the full cost of such protection. Enrollees would pay a monthly part A premium based upon the estimated cost of hospital insurance protection for persons eligible to enroll plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any; such premium would be \$33 a month through June 1974 and would be adjusted for each 12-month period thereafter to reflect both the experience of the group and any changes in costs.

The monthly premium for persons in the group who enroll for part B would be twice the premium paid by an individual who has attained age 65 until June 1974 and would be adjusted for each 12-month period thereafter to reflect the estimated cost of supplementary medical insurance protection for persons eligible to enroll under the provisions plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any. Aliens who have been in the United States less than 5 years and persons who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee bill would require, as it requires under the provision in the bill making medicare protection available to uninsured persons aged 65 and over, that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. If a person terminates his supplementary medical

insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Coverage would be initially available as of July 1, 1973, to enrolled eligible persons.

Maternal and Child Health Project Grants

(Sec. 291 of the bill)

The 1967 Amendments to title V of the Social Security Act authorized \$350 million for 1972 and each year thereafter for Maternal and Child Health Services. The 1967 provision contained an allocation formula which divided the title V authorizations as follows:

- (a) 50 percent of any appropriations for formula grants to the States
- (b) 40 percent of any appropriations for special project grants
- (c) 10 percent of any appropriations for research and training grants.

The intent of this portion of the 1967 Amendments was to divide available funds in this fashion for a few years so that the Federal Government could fund innovative special projects which States might not be able to fund out of their formula grants. The special project grants were to terminate as of fiscal year 1973 and the project moneys converted to the formula grants. The rationale underlying this approach was that after a few years time, States would recognize the value of worthwhile projects and continue to support such project grants as part of an overall State program for improving maternal and child health.

Two problems have developed since the present law was enacted. First, the special project grants have been utilized primarily in urban areas, while the formula grants, on the other hand, are weighted in favor of rural States. Thus, a significant shift of funds from urban States with project grants to rural States without project grants would occur, if the project grant authorities were terminated as presently scheduled. Additionally, many project grant directors have indicated that because of other pressures on State finances, State health departments would be reluctant to use new formula grant funds to continue support for project grants, however worthy they might be.

The committee is concerned with the risk of terminating worthy projects and also recognizes the need for a full evaluation of performance under and reassessment of the maternal and child health program and its inter-relationship with broader issues of revenue sharing and national health insurance.

The Congress recently approved an extension of the project grant authority to June 30, 1973. To assist orderly budgeting by grantees and to provide time for proper evaluation of the program the Finance

Committee has approved an amendment which extends for an additional fiscal year (i.e., through June 30, 1974) the present special project grant authorization contained in title V.

**Waiver of Beneficiary Liability in Certain Situation Where
Medicare Claims Are Disallowed**

(Sec. 213 of the bill)

Under present law, whenever a medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary. This is true even where the program has paid the claim and subsequently reopens and disallows it. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

The committee bill amends title XVIII so that the beneficiary could be "held harmless" in situations where claims were disallowed because the expenses were incurred for services which were not reasonable or necessary for the diagnosis or treatment of an illness or injury or where the expenses were for custodial care and the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether the provider utilized due care in applying medicare policy in his dealings with the beneficiary and the Government.

Where both the provider and beneficiary exercised due care (i.e., they did not know, and had no reason to know, that noncovered services were involved), the liability would shift to the Government and payment would be made as though covered services had been furnished. However, in making such a payment it would be necessary to make certain that the provider and patient are put on notice that the service was noncovered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case (or similar types of cases in the instance of the provider) they could not show they had exercised due care. Thus, the Government's liability would be progressively limited.

Where the provider did not exercise due care, but there was good faith on the part of the beneficiary, liability would shift to the provider. The provider would be told that he could appeal the intermediary's decision both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the program in turn would indemnify the beneficiary (subject to deductibles and coinsurance). The indemnification could then be treated as an overpayment against the provider and recovery would be effectuated through a set-off against any amounts otherwise payable to the provider.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the SSA appeals process. Where expenses were incurred

for clearly noncovered services such as routine physical checkups, eyeglasses or eye examinations to determine the refractive state of the eyes, hearing aids or examinations therefor, routine dental services or immunizations there will be a presumption made that the beneficiary and/or the provider was aware, or should have been aware, of the fact that the services were not covered.

In providing for a waiver of liability in certain cases it is not the committee's intent to modify existing provisions of law which define covered services. However, the committee also does not intend that these provisions for waiver will be construed to encourage overly strict application of coverage provisions under the assumption that beneficiaries who cannot afford to pay for the noncovered services will be relieved of the obligation to do so. For example, inpatient hospital care is now covered under medicare only when hospital services are required on an inpatient basis from a medical standpoint. The decision as to the point in time when an individual no longer requires the hospital level of care—i.e., when he can be cared for as an outpatient or in a less costly type of facility—requires a careful exercise of professional judgment and considerable weight should be given to the attending physician's opinion because of his much greater familiarity with the patient's needs. Under certain circumstances, it may be reasonable to keep a medicare patient in the hospital even though he required only an extended care facility level of care. Sometimes there may be no extended care facility bed available. Or, there may be a period of a few days at the conclusion of a hospital confinement when a convalescing patient requires only an extended care level of services but where, as a practical matter, it would be unreasonable to transfer the patient to an extended care facility for such a short period of time. Similarly, there are situations where a terminal hospital patient could be discharged to another institution or his home a few days before his death but where it would not be economical or humane to do so. In these cases, it would continue to be appropriate to approve the few additional days of the hospital stay that are involved.

However, where the patient remains in the hospital beyond the point where it would have been practical to transfer him to a less intensive setting, coverage ends as of the time when, based on the information that was available at the time, it would be reasonable to expect the transfer to have been made. Payment of benefits for hospitalization beyond that point could be made only if the hospital's and patient's liability for the costs incurred can be waived.

The provision would be effective with respect to claims filed after the month of enactment or if filed before or in the month of enactment was for services provided on or after July 1, 1971, and for which final determinations have not been made.

Family Planning Services

(Sec. 299E of the bill)

The committee bill provides for an increase in Federal funding of family planning services for present and former welfare recipients of child-bearing age and also for those persons likely to become recipients

in the absence of such services by authorizing 100 percent Federal funding for State family planning programs, including both information counseling and the provision of medical and social services.

The committee believes that its amendment will give impetus to the availability and provision of family planning services in the States. A beginning was made in 1967, when provisions were included in the social security amendments which required that family planning services be offered on a voluntary basis, to all appropriate AFDC recipients, and authorized 75 percent Federal matching funds for this purpose. In addition the same matching was made available to the States on an optional basis for services for former or potential recipients of welfare.

The progress which has been made under the 1967 amendments, however, has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that all appropriate AFDC recipients be provided family planning services has not been fulfilled. The report states:

Many problems, of course, remain. Medical services [family planning] still are too limited, especially in rural areas but frequently in large urban areas as well. Replying to the question whether medical family planning programs currently available are adequate to meet the needs of eligible clients, 36 State welfare agencies answered in the negative in March, 1970. Thirty-one cited geographic inaccessibility as a major problem. Many reported a shortage of health professionals and paraprofessionals and some reported that existing facilities are overcrowded. Even in the Nation's principal counties and cities where clinics are more likely to be found than in less populous sections, 50 out of 106 local welfare agencies reported that currently available medical planning programs are inadequate.

Looking at their own capability of providing family planning services, many State and local welfare agencies report a shortage of staff to provide services and to arrange for adequate follow-up. Training programs for staff have not been mounted on the scale required. Although Federal funds may be used to match \$3 for every \$1 spent from State funds for services, time and again agencies emphasize the difficulty of raising the 25 percent share at State and local levels. Generally, no special funds have been made available to develop family planning services, as indicated, for example, by the general absence of full-time staff leadership for this program. Expectations among some groups that title IV funds would be available to reach substantial numbers of low-income families not currently receiving welfare have not been realized. . . .

Evidence indicates the situation is not significantly improved today. The committee is persuaded that the 75 percent Federal matching percentage, although a major step in promoting family planning services, has not been sufficient to achieve the aims of the Congress. By

providing 100 percent Federal funding, the committee bill will remove any existing financial barrier to the availability of family planning counseling and services to those desiring those services.

The committee amendment would authorize States to make available on a voluntary and confidential basis family planning counseling, services, and supplies, directly and/or on a contract basis with family planning organizations (such as Planned Parenthood clinics and Neighborhood Health Centers) throughout the State, to present, former, or potential recipients including any eligible medically needy individuals who are of child-bearing age and who desire such services.

In addition to the provision of counseling, services and supplies designed to aid those who voluntarily choose not to risk an initial pregnancy, emphasis would be placed upon assisting those families with children who desire to control family size in order to enhance their capacity and ability to seek employment and better meet family needs.

The Secretary would be required to work with the States to assure that particular effort is made in the provision of family planning services to minors (and non-minors) who have never had children but who can be considered to be sexually active; for example, persons who have contracted venereal diseases, etc.

The Secretary would also be required to work with States to assure maximum utilization of persons participating in the Work Incentive Program as family planning aides and to perform related jobs.

In order to assure that States do in fact inform welfare recipients and other eligible persons of the availability of family planning services, and that those who so desire receive the necessary medical and counseling services the amendment would reduce the Federal share of AFDC funds by 2 percent, beginning with calendar year 1974, if a State in the prior year fails to inform at least 95 percent of the adults in AFDC families and on workfare of the availability of family planning services and/or if the State fails to actually provide or arrange for such services for 100 percent of those persons desiring to receive them.

Because of the difficulties of enforcing or monitoring the mandatory provision of family planning services to former or potential recipients, the penalty provision will be limited to the offering and provision of services to present adult recipients of AFDC and workfare. However, family planning services must be offered and made available on an optional basis to former and potential recipients of child-bearing age.

It is envisioned that individuals of child-bearing age applying for or receiving AFDC would formally acknowledge that they have been informed that they are eligible to receive family planning services on a voluntary and confidential basis. If they desire family planning services, an appointment would be set up at that time and a copy of the form would be sent to the clinic or physician providing necessary services and supplies. This would not preclude "walk-in" requests for family planning assistance by present and former recipients or those likely to become recipients in the absence of such services.

The effectiveness of the program would be monitored by Federal officials on a sample basis. The operation of the program would also be subject of review by the Inspector-General for Health Care Administration.

Although the committee views family planning services as primarily medical services, it also recognizes the importance of counseling and informational services which are more traditionally considered to be social services. Therefore, the Committee amendment makes 100 percent Federal financial support for family planning services available under both the title XIX and the title IV-A programs.

The committee has amended title XIX to provide that family planning services are a mandatory service under all title XIX plans. The committee intends that the 100 percent Federal funding of family planning services through titles XIX and IV-A will reimburse for the reasonable costs of directly related family planning services.

Penalty for Failure to Provide Required Health Care Screening

(Sec. 299F of the bill)

Under present medicaid law as defined in regulation by the Department of Health, Education, and Welfare, States are required to provide health screening and treatment services for all children under 6 and eligible for medicaid by February 7, 1972, and to provide screening and treatment services to all eligible children up to age 21 by July 1, 1973.

The medicaid health screening and treatment regulation requires States to assure that eligible children receive early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered, within the limits of the State plan; and that in addition, eye-glasses, hearing aids and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the State plan, subject however to such utilization controls as may be imposed by the State agency.

Although States are required to provide treatment services indicated as necessary by the screening only to the extent that they are covered under the State plan or are required by the regulation, it is expected that States will be responsible for referring eligible children to other sources for uncovered services, and will make every effort to arrange for their provision. The regulation further requires States to establish administrative mechanisms to identify available screening and diagnostic facilities. States are also required to assure referral of appropriate children to the title V (maternal and child health) grantees for care and services, and to effect agreements to assure maximum utilization of existing screening, diagnostic, and treatment services provided by other public and voluntary agencies such as child health clinics, neighborhood health centers, day care centers, nursery schools, school health programs, family planning clinics, maternal clinics, and similar facilities.

The committee recognizes the significance of early detection and treatment of illness in children—both in human and economic terms—and therefore believes that the possibility of a reduction in Federal matching AFDC funds would serve to assure that States implement the title XIX requirements for health, screening, diagnosis, and treat-

ment for eligible children. Moreover, it would underline the committee's intent that the health screening programs should be fully implemented by the States.

The committee has therefore approved an amendment which specifies that the Federal share of AFDC matching funds would be reduced by 2 percent beginning in fiscal year 1975 if a State in the prior year has (a) failed to inform at least 95 percent of the AFDC families of the availability of child health screening services for children of ages eligible for such services; or (b) failed to actually provide for or arrange for such services; or (c) failed to arrange for or refer to appropriate corrective treatment children disclosed by such screening as suffering illness or impairment.

Because of the difficulties of monitoring the mandatory provision of screening, diagnosis and treatment service to eligible medically needy children, the penalty provision will be limited to services to children in cash assistance families. However, medically needy children are entitled to these services, and States have an obligation to provide them in accordance with the law and regulations.

Although the penalty for noncompliance by States with the child health screening and treatment regulation would not become effective until July 1, 1975, States will be expected to have health screening and treatment programs for eligible children under age 21 by July 1, 1973, as required by medicaid regulation.

Care and Treatment for Drug Addicts and Alcoholics

(Sec. 299G of the bill)

BACKGROUND

Federal statutes and legislative history are silent in terms of specific references concerning the eligibility of alcoholics and drug addicts, on account of these diseases, for public assistance under the program of Aid to the Totally and Permanently Disabled (APTD). However, the Department of Health, Education, and Welfare has ruled that otherwise eligible persons whose primary disabling condition was alcoholism or addiction could be classified at the option of a State as eligible for APTD.

In June 1970, some 12,000 APTD recipients were classified as disabled with a primary diagnosis of alcoholism. The Department of Health, Education, and Welfare estimates, in general terms, that, nationwide, under the HEW ruling approximately 200,000 alcoholics are potentially eligible for APTD because of low income and assets. Also, based upon Department of Health, Education, and Welfare data, as many as 200,000 drug addicts may be eligible or potentially eligible for APTD because of low income and assets.

APTD recipients are eligible for cash maintenance payments, medicaid and social services. A recent Department of Health, Education, and Welfare agreement with the State of New York resulted in the definition of social services for addicts being broadened to include many medical services. This agreement resulted in increased Federal funds for New York because social services receive 75 percent Federal

matching, whereas medicaid services in New York are matched at only 50 percent. In addition many services which previously had not been considered eligible for Federal matching were reclassified as social services and now qualify for 75 percent Federal matching.

HOUSE BILL

Under the House bill, alcoholics and addicts meeting the definition of disability would not receive cash assistance if treatment were available which they refused. The House bill did not provide any mechanisms for assuring the care and treatment of those addicts and alcoholics on welfare.

COMMITTEE CONCERN

The Finance Committee is concerned that this provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or while only being nominally involved—in treatment programs. Related to this is the obvious problem of alcoholics and addicts using welfare payments to support their addiction or alcoholism. By the nature of their illness, alcoholics and addicts might well use cash assistance to support their alcoholism or addiction rather than for the purposes for which it was provided.

COMMITTEE PROVISION

The committee has therefore approved an amendment precluding eligibility of medically determined alcoholics and addicts for welfare under the program of Aid to Families With Dependent Children (AFDC) and for benefits, on the basis of disability, under the Supplemental Security Income program. Thus addicts and alcoholics may not be eligible for income maintenance under AFDC and the Supplemental Security Income program in the future. Instead the committee bill would establish a program under title XV of the Social Security Act designed to encourage appropriate care and treatment of alcoholics and addicts.

The committee amendment provides that alcoholics and addicts who are otherwise eligible for AFDC, in a State (in terms of residency, income and resources) or for Supplemental Security Income and who also meet a definition of eligibility parallel to the social security program's definition, that is, who are unable to engage in any substantial gainful activity (regardless of whether required to engage in such activity) by reason of a medically determinable (by a physician qualified to make such determinations) addictive dependence upon drugs or alcohol which has lasted or can be expected to last for a period of 12 months or more—would be eligible to receive help through an alcoholism and/or addiction treatment program which would be established under title XV, if the State chooses to institute such a program.

Recent Federal legislation, particularly the Alcohol Abuse and Treatment Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, defined a broad expanded Federal role in dealing with problems of alcoholism and addiction. The Comprehensive Alcohol Abuse and Alcoholism Treatment Act authorized the establishment of the National Institute on Alcohol Abuse and Alcoholism to develop and conduct comprehensive programs of research, and control of alcohol

abuse and alcoholism. The Drug Abuse Office and Treatment Act of 1972 (approved March 21) expanded existing programs for the control of drug abuse and provided for the coordination of all Federal efforts relating to drug abuse, treatment, education and research. Each statute also authorized a new formula grant program for assistance to States in planning, establishing, maintaining, coordinating and evaluating alcoholism and drugs abuse projects, respectively. In order to qualify for the formula grants under either Act, a State must submit a plan for attaining the goals of each program and must designate or establish a single State agency for preparation and administration of each plan. To date, all States have an active State agency designated pursuant to the provisions of the Alcoholism Treatment Act. A majority of the States have an agency which would meet the statutory requirements of the Drug Abuse Treatment Act, and all fifty have some agency charged with coordinating current efforts to control drug abuse.

In order to coordinate the new title XV program with these recently established drug and alcohol abuse treatment programs, title XV funds would be made available only to local treatment agencies, institutions, practitioners, and organizations which are certified to be appropriate and qualified to provide such care and treatment by the designated State drug or alcohol abuse and treatment agency. Once enrolled in the title XV treatment program, the alcoholic or addict would be referred to a local treatment organization or agency. There would be no independent separate programs of care and treatment for the alcoholics and addicts under the welfare laws.

To be eligible for reimbursement under title XV, the individual treatment program must be carried out under a professionally developed plan for rehabilitation designed to terminate dysfunctional dependency upon alcohol or drugs. The rehabilitation plan must be reviewed (and modified as necessary) at three month intervals in order to formally evaluate the adequacy and continued necessity of the care and treatment. However, to assure continuity of necessary care and treatment, the initial medical determination of addiction or alcoholism could be deemed valid for up to 12 months. Additionally, this review requirement is intended to guard against pro forma application of the rehabilitation plan. The plan of treatment must include to the maximum extent feasible work rehabilitation. Authorities in treatment and rehabilitation of alcoholics and addicts have strongly emphasized the importance of work therapy as part of a comprehensive plan of rehabilitation and the committee bill incorporates this desirable feature.

Further, the Secretary and the Inspector General would be required to regularly determine that pro forma compliance was not being undertaken. Federal matching funds would be automatically terminated for medically determined alcoholics and addicts not involved in an active program.

In a State which provides assistance under Aid to Families with Dependent Children, to persons medically determined to be alcoholics or addicts, such persons would have to be referred for care and treatment to the Title XV agency as a condition of continued eligibility for Federal matching. Refusal of care and treatment by an addict or

alcoholic would result in termination of assistance payments and medicaid for that individual.

Similarly, in States which do not opt to establish a title XV program, alcoholics and addicts will not be eligible for any federally matched cash assistance payments. The same conditions apply to addicts and alcoholics eligible for benefit under the supplemental income program on the basis of a disability.

MAINTENANCE OF FISCAL EFFORT

To assure maintenance of expenditure levels in the primary Federal and State programs directed toward treatment and rehabilitation of alcoholics and addicts, and to avoid any shifting of those expenditures to title XV, the amendment would provide that: If a reduction in Federal, State, or local expenditures is made, either through reduction in appropriations or expenditure levels (including impounding of appropriated funds), then the Federal matching funds available under title XV would be reduced proportionate to the other decreases.

Funds spent under the program for supportive assistance payments and medicaid payments to persons otherwise eligible for those payments and services under a State plan (and who are receiving care and treatment under title XV) would be excluded from the amount determined to be spent for care and treatment for purposes of calculating levels of fiscal effort.

The Finance Committee is also concerned that some States have circumvented the intent of present law in efforts to obtain higher Federal matching for services to rehabilitate alcoholics and addicts. Services which are health related should be reimbursed under the medicaid matching rates and not as social services. The committee amendment provides that matching under title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at the medicaid rates and cash payments and defined social services would be matched or otherwise financed at the rate applicable to the category under which the person would otherwise be aided.

To the extent that at least 50 percent of medically determined alcoholics and addicts are not enrolled and receiving active care and treatment under title XV within 6 months of enactment of the amendment States would lose Federal matching for those not in treatment; similarly at least 75 percent must be enrolled and in treatment within 9 months and all such persons brought into title XV by the end of 12 months.

SUPPORTIVE ASSISTANCE FOR ALCOHOLICS AND ADDICTS

As described, the committee amendment makes medically determined alcoholics and addicts ineligible for payments under the AFDC program and the supplemental income program. Owing to the nature of their illnesses, alcoholics and addicts might well use these payments to support their alcoholism or addiction rather than for the purposes for which the assistance was provided.

The committee's concern is shared by many individuals and agencies active in the treatment of alcoholics and addicts. For example, in a

recent letter to the committee, the Association of Voluntary Agencies on Narcotics Treatment, Inc (AVANT) of New York stated:

"The tragedy in New York and other major cities is that there are not enough treatment facilities like the member agencies of AVANT. Welfare officials claim they frequently approve welfare payments to addicts not in treatment because the addicts in question cannot get into crowded treatment programs. These officials naively ignore the fact that the addicts will immediately use the money for drugs."

"The solution to this dilemma is not to keep dispensing more money * * * but to provide more treatment facilities and to enact stronger legislation requiring abusers of all illicit drugs to undergo treatment."

It is recognized that, in some cases, the plan of proper treatment or rehabilitation could be furthered with protective payments for the enrolled alcoholic or addict's needs with respect to food, clothing and shelter. Therefore, the committee amendment provides that in those specific cases where it is determined that proper treatment or rehabilitation would be aided by protective assistance payments, such assistance could be granted in a fashion which would support the treatment activities, but only to persons otherwise eligible in a State for aid or assistance (except for their medically determined alcoholism or drug addiction). To the extent that an enrollee received food, clothing and shelter in an institutional or other setting, protective payment amounts, if any, would be adjusted accordingly. At certain stages of treatment, it is conceivable that supportive payments could be made (in whole or part) directly to the enrollee where those in charge of his treatment determine that direct support would enhance rehabilitation and further capacity for independent living. The amendment authorizes exceptions, in such cases, to the protective payments approach. The determination as to whether protective payments are necessary to support the treatment plan would have to be specifically reevaluated at least every three months. Such payments could be no greater than comparable payments under the appropriate cash program and would be made by the title XV agency. Authorization as to payments and frequencies thereof, would usually be based upon the recommendation of the local treatment program.

Payments would come from funds for the cash program for which the person would otherwise be eligible.

Modification of the Role of the Health Insurance Benefits Advisory Council

(Sec. 288 of the bill)

The Health Insurance Benefits Advisory Council (HIBAC), established under the 1965 Social Security Amendments, advises the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the medicare program, including the formulation of regulations. The 1967 amendments expanded the functions of the Council to include the responsibility for reviewing and reporting to the Congress on the effectiveness of the medicare program and on

possible improvements in the administration of the program and in the law itself.

In keeping with its concern that the proliferation of advisory bodies in HEW be periodically evaluated, the committee has found that the need for and role of the Health Insurance Benefits Advisory Council have substantially changed since the initiation of medicare. During the formative years of medicare there was some advantage to having a group such as HIBAC, broadly representative of the major health care interests, to review and offer recommendations to the Secretary on the formulation of a large body of regulations and program policies. However, much of that work is now completed, and there seems little need for permanent authority to deal with the often routine modifications and refinements in medicare in view of the program's present status and the development of administrative expertise and capabilities. The National Professional Standards Review Council, which would be established under the PSRO amendment previously approved by the Committee, would undertake functions with respect to evaluation of utilization of health care services presently part of HIBAC's charge.

The present status of medicare would seem to require different kinds of advice from outside advisors. During the initial years of the program, advisory bodies broadly representative of the major health care interests were a source of information about the possible reactions of their constituencies to proposed policies and regulations. Now that the major policy features of the program have been established and additional formal and informal lines of communication with the major interests set up, there is a decreased need for such advice. For example, the Department has established formal consultation procedures with medicare carriers and intermediaries to deal with operational problems related to the claims process.

The committee has, therefore, added to the House-approved bill a provision that modifies the role of the Health Insurance Benefits Advisory Council so that its role would be that of offering suggestions for the consideration of the Secretary on matters of general policy in the medicare and medicaid programs.

Durable Medical Equipment

(Sec. 245 of the bill)

Present law provides for reimbursement under part B of the medicare program for expenses incurred for the rental or purchase of durable medical equipment used in the patient's home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, medicare reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented. Payments continue for as long as the equipment is medically required by the individual's condition or until the total of the monthly installments paid equals 80 percent of the reasonable purchase price less an applicable portion of the deductible, whichever comes first. Payment in the case of the purchase of inexpensive equipment (presently defined as equipment for which the reasonable

charge is \$50 or less) may be made in a lump sum if such method of payment is less costly or more practical than periodic payment.

Where the beneficiary elects to rent, the program is bound to continue indemnifying him for his rental expenses as long as his medical need for the item continues. Extensive review by the General Accounting Office showed that rental payments for durable medical equipment often exceed the purchase price. Where it is reasonably predictable that rental cost would exceed the cost of purchase but the equipment is nevertheless rented, the rental provision may impose unreasonable expenses on the program.

The committee has added to the House bill a provision to help avoid unreasonable expenses to the program which result from prolonged rentals of durable medical equipment. The Secretary of Health, Education, and Welfare would be authorized to experiment with reimbursement approaches (in various geographic areas) which are intended to prevent these unreasonable expenses and to implement without further legislation any purchase approach found to be workable, desirable, and economical. The committee suggests that among the possible approaches to be evaluated would be the feasibility of suppliers contracting with the Secretary of Health, Education, and Welfare under arrangements whereby rental would be undertaken by means of lease-purchase arrangements which provided for rental payments to terminate when an agreed-upon total for purchase was reached; under another approach, medicare payment for a covered item of durable medical equipment would be made to the supplier in a lump sum where it was determined, in accordance with guidelines of the Secretary, that outright purchase would probably be more economical than lease-purchase; another approach would be to encourage beneficiaries to purchase used equipment by waiving the present 20-percent-coinsurance requirement where the purchase price of the used equipment was at least 25 percent less than the reasonable price of new equipment.

Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers Under Medicare and Medicaid

(Sec. 249C of the bill)

As part of his responsibility for administration of the medicare program, the Secretary, through the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers, intermediaries and State agencies—which assist in program administration. In addition the Social Security Administration prepares program validation review reports, which are used as management and audit devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own medicare operations and of indicating necessary corrective follow-up action with respect to both the provider as well as the intermediary.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual con-

tractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The committee recognizes the dilemma which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractors and provider performance with the accompanying pressures for improvement in administration that only such awareness can bring as well as the desire to conform with the overall intent of the Freedom of Information Act. On the other hand, these evaluations and reports require review of details some of which do not provide a basis for conclusion as to overall performance and the initial evaluation may not always be based on all the pertinent facts. The possible release of portions of a report which may include unqualified or incomplete information may be unfair to the contractors or providers. The committee recognizes that when there is public disclosure of this type of information on contractor performance there is a need to provide contractors with sufficient opportunity to respond to the information in the reports before their publication so as to avoid release of possibly erroneous findings, without rebuttal, which might prove damaging to their reputation.

The committee bill would require that the Secretary make public the following types of evaluations and reports dealing with the operation of the medicare and medicaid programs: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of followup reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals deleted.

The bill would require prompt and timely public disclosure of reports prepared by the Secretary and submitted to any contractor or provider of services for review and comment after the third month following enactment. Such reports would include only those which are official in nature and would not include internal working documents such as informal memoranda. Under the bill, public disclosure of evaluations and reports would not be required to be made until the contractor, State agency, or facility was given suitable opportunity—not to exceed 60 days—for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment. The reports would not be required to contain information concerning those deficiencies which are known by the Secretary to have been fully corrected within 60 days of the date they were initially brought to the attention of the contractor or provider of services.

It is the committee's intent that the requirement of disclosure of such evaluations and reports not lessen the effort of the Secretary in his present information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting any disclosure of information otherwise required under the Freedom of Information Act.

Requirement for States To Deem Eligible for Medicaid Those Assistance Recipients Who Would Lose Eligibility Because of 20-percent Social Security Increase

(See 249D of the bill)

The Congress recently passed legislation (Public Law 92-336) providing a 20 percent increase in social security benefits effective September 1, 1972. As a result of this increase an estimated 190,000 aged, blind, and disabled persons will lose their eligibility for cash assistance and will be moved off the cash assistance rolls. Approximately half of these persons reside in States which have no medically needy program. Their loss of cash assistance eligibility will therefore preclude them from receiving any medicaid coverage.

Persons residing in States with medically needy programs who are removed from the cash assistance rolls are insured against permanent loss of medicaid eligibility. In these States, categorically related individuals may lose their medicaid coverage if their income resources exceed the State's eligibility standards for medicaid, but they may regain coverage after having incurred medical costs equal to the amount by which their income exceeds the standard. This is the so-called "spend-down" feature.

Title XIX requires States with a medically needy program to disregard in determining income all expenses incurred by an individual for medical and remedial care recognized under State law in the process of determining an individual's eligibility for medicaid. This provides a limit on the medical costs a person must absorb from his own income before he is eligible to receive assistance under medicaid. Thus, while under present law the social security benefit increase could result in a loss of medicaid coverage in those States for cash assistance recipients who are receiving assistance in an amount less than their social security benefit increase, these categorically related individuals could regain medicaid coverage after "spending down" a specified amount of their income on covered medical care. In States without programs covering the medically needy, however, persons who lose their medicaid eligibility because of the increase in social security benefits have no similar recourse. When they lose their cash assistance, they lose all opportunity for medicaid coverage no matter how high their medical bills or how pressing their medical needs.

The committee is particularly concerned that the recently passed social security benefit increase should not force formerly eligible individuals to lose all medicaid coverage. It has therefore included a provision in the bill which would require that in those States which limit medicaid coverage to categorically needy persons (recipients of cash assistance or persons who would be eligible for cash payments except that they reside in an institution), no person who was medicaid-eligible in August 1972 could be deemed ineligible for medicaid solely because of the increase in income resulting from the 20 percent increase in social security benefits voted by the Congress in June 1972. In implementing this provision, a State may have the option of requiring a person who leaves the cash rolls because of the social security

increase to incur medical expenses in the amount of the excess income resulting from the benefit change before he receives medicaid coverage (in effect, instituting for these persons a spend-down similar to that applied in States with programs for the medically needy). Alternately, a State may simply disregard that amount of the social security benefit increase by which income exceeds the standard for purposes of determining medicaid eligibility. Such a disregard would not be applicable for purposes of the cash assistance program.

The committee has included this amendment to prevent total loss of medicaid coverage to individuals who lose eligibility as a result of the recently enacted increase. This amendment will not preclude persons, residing in medically needy States, from losing their eligibility as categorically needy persons and becoming medically needy (subject to State requirements including the spend-down provision).

Preventing Payment for Institutional Health Care Under the Cash Welfare Programs to Avoid Compliance With Medicaid Standards

(Sec. 249(E) of the bill)

Under present law (Section 121(b) of Public Law 89-97), no Federal matching payment may be made to any State under the cash assistance programs with respect to "aid or assistance in the form of medical or any other type of remedial care" for any period for which States receive title XIX payments or for any period after December 31, 1969. The Department has restricted application of the 1965 provision to prohibit only vendor payments for medical or remedial care. States therefore have the option of including the cost of medical service in the cash welfare payment to recipients. To date, States have had little incentive to use this cash grant method of payment, although there is evidence that some States have used this device to avoid application of medicaid standards to some substandard nursing homes and intermediate care facilities.

The Department of Health, Education, and Welfare is currently engaged in efforts to strengthen enforcement of skilled nursing home and extended care facility standards in accordance with statutory requirements. With the recent transfer of the administration of intermediate care facilities to the title XIX program, Federal efforts have also been directed toward development and enforcement of standards and statutory requirements for these facilities. The committee has included a number of important provisions designed to upgrade long-term care services and facilities and strengthen the Federal Government's enforcement activities. The combination of these efforts will require a large number of facilities, currently receiving title XIX matching funds, to make substantial improvements in order to remain eligible providers.

The committee is concerned that a number of substandard skilled nursing facilities and intermediate care facilities may seek to avoid the burden of correcting their deficiencies. Under current practice, they could withdraw from the medicaid program and possibly force the State agency to continue the support of patients in these homes by adding the cost of care to the patients' monthly welfare payments.

The committee has therefore included a provision to preclude Federal matching for that portion of any money payment which is related to institutional, medical, remedial or other care which is (or could be) included under the medicaid program. The thrust of this provision is to bar using the cash grant system to finance nursing facility care and services in intermediate care facilities as a means of avoiding application of title XIX standards for facilities providing these services. It is not expected to relate to other title XIX services—such as dental care or prescription drugs—which are generally not delivered in an institutional setting (except to the extent such services are defined by the Secretary to be an essential part of skilled nursing facility or intermediate care facility services).

A facility providing care which in general resembles or is similar to that provided under medicaid but which fails to meet Federal requirements could not seek to circumvent application of this provision with the claim that since it did not meet title XIX standards and was not a title XIX facility, its services could not be considered title XIX services and were therefore not subject to this restriction. Any cash recipient receiving care in an institution which could, if it upgraded its services or facilities, be an eligible provider would be precluded from receiving Federal matching for that portion of his payment which is related to institutional, medical, remedial, or similar care. States would continue to receive Federal matching for payments to persons to finance the cost of room and board in the case of recipients who require no health related services beyond room and board. In determining whether cash grant payments for institutional care were being used to subvert the intent of this provision, however, it is expected that the Department would carefully examine the amount of payment included for the purchase of room and board and compare it to amounts expended for title XIX institutional care; a significant differential in the amount of this payment and the average payments for ICF or skilled nursing home care would be expected. In addition, the State would have an obligation to demonstrate to the satisfaction of the Secretary that persons residing in an institutional setting, financed through the cash grant programs, (1) were not receiving intermediate care facility services or skilled nursing home care and (2) were not in need of such services—i.e., were appropriately placed in such facilities.

Conditions of Coverage of Outpatient Speech Pathology

(Sec. 283 of the bill)

At present, speech therapy services are covered under medicare when provided by approved hospitals (on both an inpatient and outpatient basis) or home health agencies. The services may be provided by an employee of the provider or by an outside source (agency, clinic, or independent practitioner) under contract to the provider. Speech therapy services are also covered under part B as incident to physician services, provided they are furnished under the direct supervision of the physician.

While speech pathology services are generally useful to aged persons with certain disorders, such services are sometimes unavailable to the

aged due to the small percentage of speech pathologists who are employed by providers eligible to participate in the medicare program. Part of the problem is the fact that the outpatient services must be provided under the direct supervision of a physician.

The committee has approved an amendment providing that medicare part B coverage include speech pathology services—the same services now covered as speech therapy when furnished as a provider service—furnished to beneficiaries on an outpatient basis by organized agencies, clinics or other health centers without necessarily requiring direct physician supervision of such services. Generally, an organized setting would be one in which two or more qualified practitioners are furnishing covered services. Providers would be required to meet conditions established by the Secretary to assure proper coordination, continuity, and quality of care. Individuals should continue as under present law, to be referred by a physician for services furnished by or under the direct supervision of a qualified speech therapist, under a plan for the individual's total care, established and periodically reviewed by the physician who retains overall responsibility for the individual's care. Reimbursement for services would be made to the agency, clinic, or center on the basis of reasonable cost. The amendment would be effective with respect to services furnished after December 31, 1972.

Conditions of Coverage of Services of Clinical Psychologists

(Sec. 284 of the bill)

Coverage of the services of clinical psychologists is presently available on a basis which includes a requirement that the services of such psychologists must be provided as part of hospital or extended care services or under direct physician supervision.

The requirement that outpatient services of such psychologists be rendered under direct physician supervision apparently restricts the availability of such services to the elderly as there are many psychological clinics which are not physician-directed.

The committee has approved an amendment which would liberalize the coverage provision under part B limiting coverage of outpatient services of a clinical psychologist to those provided under direct physician supervision retaining, however, the other requirements of present law as well as those additional general requirements described with respect to broader coverage of speech therapy including that which would require an organized setting to be one in which two or more qualified practitioners are furnishing covered services. Additionally, with respect to psychological treatment, such costs would be included in and limited by the overall \$250 annual limitation on outpatient treatment of mental illness, as they are under present law when furnished by physicians. The amendment would be effective with respect to services furnished after December 31, 1972.

Coverage of Podiatric Residents and Interns

(Sec. 276 of the bill)

The Social Security Amendments of 1967 amended the medicare definition of "physician" to include podiatrists. However, no change

was made in the definition of "approved" teaching programs in hospitals, which include the intern and residency programs of other medicare "physician" professionals. (Services provided to hospital inpatients by participants in such approved teaching programs are reimbursable on a cost basis under the hospital insurance program.) The committee bill would remove this anomaly by including within the definition of approved teaching programs the services furnished by an intern or resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

This provision would be effective with respect to accounting periods beginning after December 31, 1972.

Outpatient Rehabilitation Coverage

(Sec. 285 of the bill)

Medicare beneficiaries who are not inpatients of hospitals or extended care facilities, or homebound and entitled to home health services, have limited access to certain restorative and rehabilitative services. While part B of medicare presently covers outpatient physical therapy services furnished by providers of services, including clinics, rehabilitation agencies, and public health agencies, similar coverage for rehabilitation services which are useful to older people is not provided in certain types of settings under present law. Thus, medicare payment cannot be made for services furnished by free-standing rehabilitation facilities which provide a range of rehabilitation services on an outpatient basis which would be covered under existing law if they were provided by participating home health agencies or by hospital outpatient departments. The committee has therefore included an amendment so that, with appropriate assurances of quality of care, safety of the patient, and reasonable costs, such services would be more accessible to beneficiaries.

The committee bill establishes a new benefit category which would permit reimbursement under part B for outpatient rehabilitation furnished in organized settings. The new benefit would cover physical therapy, speech pathology, occupational therapy, and medical social services, provided on an outpatient basis by qualified outpatient rehabilitation facilities including providers of services, clinics, rehabilitation agencies, and public health agencies. A physician would have to certify that the services are required by an individual who needs physical therapy or speech pathology services and the services must be furnished in accordance with a plan established and periodically reviewed by a physician. The plan would prescribe the specific types of rehabilitation services to be provided and the amount and duration of such services.

The requirements that organizations must meet in order to provide the new outpatient rehabilitation benefit would be similar to the types of standards now imposed on providers of outpatient physical therapy services. These requirements are intended to assure that only health care of proper quality will be paid for. The facility would be required to satisfy conditions relating to medical records, policies governing the services provided, and State or applicable local licensing

requirements. The facility would also have to be organized so as to provide an adequate outpatient rehabilitation program for the services which it is certified to provide. This would include a requirement that they have adequate physician participation to the extent necessary to assure that the services provided are both efficient and properly related to the total medical needs of the patient. In addition, the facility would have to meet such other conditions relating to health and safety as the Secretary may find necessary.

Payments for outpatient rehabilitation services will be on the basis of reasonable costs as is now done for services furnished by other participating providers of services. For purposes of administration, it is expected that payment for outpatient rehabilitation services provided by approved facilities or by others under arrangements with them, would be handled by organizations serving as fiscal intermediaries under part A of the program. In effect, approved clinics and agencies would be treated as "providers of services" for purposes of facilitating payment for outpatient rehabilitation services and as such would have to agree not to charge any beneficiary for covered services for which payment would be made under the program and to make adequate provision for refund of erroneous charges.

The committee bill would extend the provisions of present law under which State agencies, operating under agreements with the Secretary, determine whether a provider of services meets the conditions for participation in the health insurance program, to provide that State agencies would also determine whether an outpatient rehabilitation facility meets the appropriate requirements.

The committee does not intend that outpatient rehabilitation coverage will be utilized to meet the needs of individuals whose problems are not primarily related to health care. The committee expects that the Secretary will take appropriate measures to assure that program reimbursement will be made only for services furnished to an individual who requires skilled professional services which are reasonable and necessary for the diagnosis or treatment of an illness or injury. Should the Secretary's review of payments made for outpatient rehabilitation services reveal abuses or improper utilization of such services which the statute cannot help him curb, it is expected that he will report such problems in his annual report to the Congress.

Benefits would be payable for covered outpatient rehabilitation services furnished beginning January 1, 1973.

Authority of Secretary To Select Intermediaries and Assign Providers to Them

(Sec. 286 of the bill)

Under present law, a group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization or agency to act as the "fiscal intermediary" between the providers and the Secretary of Health, Education, and Welfare. The Secretary is authorized to enter into an agreement which provides for the organization or agency to determine amounts due the providers. Any provider which either elects not to be bound by the group's nomination of an intermediary or is not a member of a group making such a nomination, may elect to be paid through

any organization or agency which has entered into an agreement with the Secretary, if the Secretary and the organization agree to it, or the provider may elect to deal directly with the Secretary. The Secretary may enter into an agreement with an organization or agency to act as a "fiscal intermediary" only if he finds that to do so would be consistent with effective and efficient administration of the program.

An agreement may be terminated by the intermediary or by the Secretary, with appropriate notice. The Secretary may terminate an agreement with an intermediary only if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

The arrangement under present law giving providers of services wide latitude in their choice of intermediaries was appropriate at the outset of the medicare program. As the program has matured, however, such unrestricted choice may be an impediment to efficient and economical administration. For example, where an intermediary is selected by only a small minority of providers in an area, it is very difficult for the intermediary to perform the cost comparisons and other analyses which are an essential component of determinations of reasonable costs. Unrestricted choice of intermediaries also raises the possibility that a provider will "shop" for the most lenient fiscal intermediary. Moreover, unrestricted choice interferes with the Administration's efforts to improve program administration by increasing the responsibilities of the most efficient intermediaries, while decreasing the roles of relatively inefficient intermediaries.

Accordingly, administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers should be strengthened. The Secretary should have the primary authority to determine to which intermediary providers may be assigned or reassigned when they wish to change intermediaries or where continued availability of a particular intermediary (or direct payment by the Secretary) in a given locale is inefficient, ineffective, or otherwise not in the best interests of the program. The Secretary should consider the preference of the provider, but should also be able to take a different course of action in the interest of effective program operation.

The committee bill would authorize the Secretary to assign or reassign providers to available intermediaries or to require that payments to a given provider be made directly by the Secretary in any case where such assignment or reassignment would result in more effective and efficient administration of the medicare program.

This provision would become effective on January 1, 1973.

Limitations on Adjustment or Recovery of Incorrect Payments Under the Medicare Program

(Sec. 281 of the bill)

Under present law, the Secretary is required to recover overpayments made to or on behalf of an individual where it is determined that services for which payment has been made were not covered under medicare. Further, present law provides that overpayments made to providers or other persons for services furnished an individual,

which cannot be recovered from the overpaid provider of services or other person, may be recovered by decreasing subsequent payments to which an individual is entitled under title II of the Act.

Present law also provides that adjustment or recovery of an incorrect payment will not be made with respect to an individual who is without fault and where such an adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience. However, there are no similar provisions specifically authorizing the application of waiver with respect to providers of services and other overpaid persons. While the Administration has developed guidelines to specify the situations where a provider of services or other person should not be held responsible for repayment of incorrect amounts, the committee has added provisions to apply where it seems inequitable to recover from a provider or the individual.

The committee is particularly concerned about overpayments discovered long after the payment was made. It has therefore, included an amendment providing that, after 3 years have expired, there will be a presumption, in the absence of evidence to the contrary, that the provider or other person shall be deemed to be without fault with respect to an overpayment and that under such circumstances no collection should be made. However, the Secretary would be authorized to make the presumption before the 3 years have expired (but not before 1 year) if he finds that to do so would be consistent with the objectives of title XVIII.

The amendment also requires that providers under their participation agreements (or physicians or other persons where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after 3 years, from charging beneficiaries for services found by the Secretary to be medically unnecessary or custodial in nature, in the absence of fault on the part of the individual who received the services. However, the Secretary would be authorized to make the presumption before the 3 years have expired (but not before 1 year) if he finds that to do so would be consistent with the objectives of title XVIII.

Additionally, the Secretary would be authorized to deny claims for reimbursement made after the lapse of a reasonable period of time specified by him in regulation, of not less than 1 year nor more than 3 years. This provision is similar to one developed by the committee in 1970 and included in H.R. 17550 as passed by the Senate.

The limit on right of recovery would apply to notices of payment after 1968. The limit on filing claims would apply to requests for payment made after 1970.

14-Day Transfer Requirement for Extended Care Benefits

(Sec. 248 of the bill)

Under present law, medicare beneficiaries are entitled to extended care benefits only if they are transferred to a skilled nursing facility within 14 days of discharge from a hospital. The committee added to the House bill a provision which would modify this requirement in certain defined cases where failure to begin receiving extended care services within 14 days would not change the nature of the services as

a continuation of treatment begun in the hospital. Intervals of more than 14 days would be permitted when, following discharge from a hospital, the patient's condition did not permit immediate provision of skilled nursing or rehabilitation services, or the nonavailability of appropriate bed space in facilities ordinarily utilized in the geographic area prevented admission for not longer than 2 weeks beyond the 14 days. The Secretary would define in regulations the criteria to be applied in determining whether the 14-day requirement can be waived.

One example of the type of situation intended to be covered is a patient with a fractured hip who may require little in the way of skilled care for some time after his discharge from the hospital because the fracture will not have mended to the point where physical therapy and restorative nursing can be utilized. In such a case, regulations could indicate that payment of posthospital extended care benefits would start when the patient begins an active program of skilled care, even though more than 14 days will have elapsed since his transfer from the hospital, since such care would be clearly related to his hospitalization. Another example would be the case where an individual was discharged from a hospital to his home rather than to a skilled facility because no bed was available and the person's illness required the use of private duty nursing on an essentially full-time basis to provide skilled care. A third example would be a person who needed daily skilled services and went home because no bed was available but lack of funds or appropriate services prevented him from receiving daily skilled care at home and the health of the patient suffered. The cost of this change would not be significant.

Consultants for Skilled Care Facilities

(Sec. 277 of the bill)

Among the conditions of participation for extended care facilities in the medicare program is the requirement that these facilities retain consultants in specialty areas such as the maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Reimbursement is made to each facility only for that portion of the costs of the consultants' services representing services provided to medicare patients. For example, if 20 percent of the patient days in an extended care facility are medicare and the remaining 80 percent are medicaid patient days, the facility can recover only 20 percent of the costs of the consultants' services from the medicare program. The remaining 80 percent of the cost must come from the fixed per diem payment made by the State for medicaid patients.

The committee is aware that in many parts of the country consultants in these particular specialty areas are in short supply, competition for their services is intense, and the cost of retaining them on a per diem basis is often prohibitive for many extended care facilities. In some cases, the difficulty encountered by an extended care facility in retaining and paying for a consultant is compounded by the fact that a large number of the facility's patients are on medicaid. Often the State has provided similar consultative services for these medicaid patients, and no additional medicaid allowance can be made for the

outside consultants employed to meet the medicare conditions of participation.

Under the committee bill those State agencies that are able and willing to provide these specialized consultative services for medicare patients in an extended care facility which requests them, would be authorized to do so, subject to approval of the State's arrangements by the Secretary. The provision of consultative services by the State agency on this basis would satisfy the medicare requirements relating to the use of consultants in the appropriate specialty areas. Payment by medicare would be made directly to the State agency for the costs incurred in rendering the consultative services. The State agency would be authorized to limit the availability of these services, consistent with its own assessment of available resources and needs.

This approach is in reality an extension of present responsibilities, since State agencies have had a consultative as well as a certifying role in medicare.

The amendment should result in lower costs to the medicare program as the consultants would be salaried employees of the State. It should also lead to more effective use of scarce personnel. Finally, determination of compliance by a facility with the required consultative services would be substantially simplified through verification at a single source—the State agency—rather than with a multiplicity of individual and scattered consultants.

A similar provision was approved by the committee in 1970 and included in H.R. 17550 as passed by the Senate in 1970.

Direct Laboratory Billing of Patients

(Sec. 279 of the bill)

Payment under medicare for low cost diagnostic laboratory tests covered under the supplementary medical insurance program presents a problem when patients are billed directly for such services by the laboratory and assign their claims for medicare payment of a portion of the cost to the laboratory. The problem is that the cost of collection of an individual bill is large compared with the amount of the bill, particularly with respect to collection of the coinsurance portion. For example, where a bill for a laboratory service is \$1.50, medicare will pay only 80 percent, or \$1.20, and the laboratory must bill the patient for the 30 cents coinsurance for which he is responsible. The cost to the laboratory of billing may exceed 30 cents, a situation which might result in the laboratory raising its fee for such service to \$2.00, so that it could collect its full charge from medicare without billing the patient for the coinsurance.

The committee therefore added a provision to the House bill, with respect to diagnostic laboratory tests for which payment is to be made to the laboratory, so that the Secretary would be authorized to negotiate a payment rate with the laboratory which would be considered the full charge for such tests, for which reimbursement would be made at 100 percent of such negotiated rate. However, such negotiated rate would be limited to an amount not to exceed the total payment that would have been made in the absence of such rate.

Authority of Secretary to Administer Oaths in Medicare Proceedings

(Sec. 289 of the bill)

Under present law, the Social Security Administration has the right to take affidavits under oath from beneficiaries, other witnesses, and principals in cases involving fraud, but only with respect to instances involving cash or disability insurance benefits (under title II of the Social Security Act). There is no provision in title XVIII which grants the same right with respect to cases involving the medicare program.

As a result, the Social Security Administration personnel have been limited in their investigations of suspected program abuses because they may obtain only statements from claimants and other persons involved in potential fraud cases, as opposed to affirmations under oath. Witnesses are less likely to change their testimony at the time of trial if an affidavit is originally taken, since they generally attach more legal significance to such an affidavit as opposed to a statement completed on an administrative form.

The committee bill therefore includes a provision which would authorize the Secretary, in carrying out his responsibility for administration of the medicare program, to administer oaths and affirmations in the course of any hearing, investigation, or other proceeding.

Termination of Medical Assistance Advisory Council

(Sec. 287 of the bill)

The 1967 Social Security Amendments established a 21-member Medical Assistance Advisory Committee (MAAC) for the purpose of advising the Secretary on matters of general policy in the administration of the medicaid program.

The committee believes that it is helpful from time to time to review the necessity for various advisory groups, and determine whether they should continue to function, or whether their responsibilities should be assumed by another existing advisory group.

Many of the areas of concern of the MAAC overlap those of the Health Insurance Benefits Advisory Council (HIBAC) under medicare. The similarities between medicare and medicaid are considerably greater and more important than the differences. Both are concerned with hospital, medical, skilled nursing facility care, and related care, as the major and most costly items of service provided. Patterns of payment and standards of care between the two programs are closely related. Further efforts to conform them even more closely, particularly in the area of long-term care, have been made by the committee in this bill, and by the Department. A single advisory group would avoid duplicative activity.

The committee has therefore approved a provision to terminate the Medical Assistance Advisory Council three months following enactment of H.R. 1. Of course the Secretary would still be free to appoint, as necessary, temporary ad hoc advisory groups to deal with specific medicaid areas of concern.

The Council's responsibility for advising the Secretary on matters of general policy affecting medicaid would be lodged with the Health Insurance Benefits Advisory Council.

Extension of 75 Percent Federal Matching for Medical Personnel Under Contract

(Sec. 282 of the bill)

Present law permits Federal financial participation at the 75-percent rate for the compensation of skilled professional medical personnel and staff directly supporting such personnel of the State agency or of any public agency involved in the administration of the medicaid program at the State or local level. Such personnel and staff include physicians; members of other health professions such as dentists, medical and psychiatric social workers, nurses, and pharmacists; other specialized personnel, such as research specialists and experts on medical costs.

Present law, however, provides only 50 percent Federal matching (the matching rate for general administration of the title XIX program) for such medical personnel in non-public organizations under contract to the single State agency administering the medicaid program. This limitation handicaps States in securing outside medical personnel on a contract basis with respect to medicaid functions.

The committee has authorized Federal matching under medicaid of 75 percent of the reasonable costs of compensating skilled medical personnel and direct supporting staff other than those of the State or other public agencies. The committee included a similar amendment in H.R. 17550 which was approved by the Senate.

States would thus be able, by contract arrangements, to use such professional personnel for independent professional and medical audits required with respect to patients in skilled nursing homes, mental institutions, and intermediate care facilities whose use might otherwise not be economical.

Increase in Maximum Federal Medicaid Amount for the Virgin Islands

(Sec. 271 of the bill)

Under present law, there is an annual ceiling of \$650,000 on Federal matching funds for the Virgin Islands' medicaid program.

Over the past several years, there have been substantial increases in the unit costs of hospital and physicians' care in the Virgin Islands which are expected to increase further. There has also been an increase in medicaid eligibles. The committee believes the \$650,000 maximum on medicaid payments to the Virgin Islands should be adjusted to reflect the impact of these factors.

The committee has approved an increase in the ceiling on Federal medicaid matching for the Virgin Islands from the present \$650,000 to \$1 million.

There would be no change in the 50 percent Federal matching rate.

The provision would be effective for fiscal year 1972 and each fiscal year thereafter.

100 Percent Federal Financing of Medicaid Nursing Home Survey and Inspection Costs

(Sec. 249B of the bill)

At present, Federal matching funds for inspection of skilled nursing facilities participating in the medicaid program are limited to 75 percent of necessary costs while reimbursement for inspection of medicare extended care facilities is 100 percent of necessary costs.

The President has recommended that survey and inspection costs of nursing facilities participating in the medicaid program be 100 percent federally financed.

Present State inspection systems for medicaid skilled nursing facilities and intermediate care facilities are less effective than they could be, due in part to the reduced reimbursement rate for these inspections which provides an incentive for States to concentrate on title XVIII reviews. Another result of this difference in reimbursement has been an inadequate number of skilled nursing facility and intermediate care facility inspectors. The committee believes that full Federal funding of the reasonable costs of nursing facility inspections would improve the present system of determining an institution's qualifications to participate in medicaid and medicare and serve to upgrade and standardize the quality of services provided by nursing facilities.

The committee has therefore added a provision to allow for 100 percent reimbursement for survey and inspection costs of skilled nursing facilities and intermediate care facilities under title XIX.

The amendment is effective January 1, 1972.

Definition of Physician Under Medicaid

(Sec. 280 of the bill)

Physicians' services are one of the mandatory items of health care services which a State must include in its medicaid program. The committee has amended section 1905(a)(5) of title XIX so as to include in the statute the definition of a physician, as originally intended, for purposes of this mandatory coverage as being a duly licensed doctor of medicine or osteopathy.

Services of other types of health care practitioners are authorized under other provisions of Section 1905(a). These other types of practitioner services would remain optional with the States in accordance with the clear intent of the committee originally expressed in 1965 with the enactment of medicaid.

This provision parallels a similar amendment added by the committee to H.R. 17550 and approved by the Senate.

Optometrists' Services Under Medicaid

(Sec. 212 of the bill)

Under present law a State can choose to provide optometrists' services as an optional service under its State plan. Some States, however, which had chosen to include this service as an optional medicaid service have dropped optometric care as a reimbursable service from their

plans, but specifically continued to provide for eye care which an optometrist is also licensed to provide under physicians' services, which is a mandatory service under title XIX.

The committee believes that such provisions circumvent the legislative intent as expressed in 1969.

Under the committee bill, a State which previously covered optometric services under medicaid and which, in its medicaid formal plan, *specifically* provides coverage for eye care under "physicians' services" which an optometrist is licensed to perform would also be required to reimburse such care whether provided by a physician or an optometrist; optometrists could not be excluded as potential providers in these cases.

Withholding of Federal Medicaid Matching Amounts for Certain Terminated Medicare Providers

(Sec. 290 of the bill)

At present there are many hospitals and extended care facilities which have withdrawn from participation in medicare without submitting cost reports to account for payments received under medicare or refunding overpayments, yet they continue to participate in the medicaid program and receive payments through that program without penalty.

This problem has been the subject of an extensive study and report by the Comptroller General in which he noted that improvements were needed at both the intermediary and Federal level of medicare to minimize overpayments. In addition he recommended that steps be taken to withhold other Federal payments, particularly under medicaid, to these institutions.

The committee amendment would authorize the Secretary of Health, Education, and Welfare to withhold (subsequent to sixty days advance notice to a State) future Federal financial participation in State medicaid payments to institutions which have withdrawn from medicare without refunding medicare overpayments or submitting cost reports to account for medicare payments to them during their participation in that program. The amendment is designed to recover funds which have been overpaid to terminated medicare providers and is not intended to penalize either the States or other title XVIII and/or title XIX providers. If the terminated providers in question enter into substantial negotiations with medicare, it is expected that the withdrawal of Federal financial participation for that provider would no longer apply.

Intermediate Care Facilities

(Secs. 297, 298, and 299 of the bill)

In order to provide a less costly institutional alternative to skilled nursing home care, the committee and 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 authorize a mechanism for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care

but not that level of care provided by skilled nursing homes or mental hospitals.

Section 254 of the House bill provides for the transfer of the intermediate care facility program from title XI to title XIX, making these facilities subject to standards set by the Secretary and services in these facilities available to the medically indigent (at State option). This provision is now unnecessary as the section was, subsequent to House action on H.R. 1, separately enacted into law as part of Public Law 92-223, with modifications, and became effective January 1, 1972.

The committee has therefore deleted section 254 from the House bill. In its place, the committee has substituted several technical amendments which clarify the committee intent with respect to the ICF provisions of P.L. 92-223. These changes make clear that: (a) independent professional review of title XIX patients is required in all intermediate care facilities (section 298) and that (b) intermediate care facility services are to be covered for individuals age 65 or over in mental institutions, as well as inpatient hospital services and skilled nursing home services (section 297). In addition, language has been included which clarifies the designation of the base period for the maintenance of effort requirement pertaining to non-Federal expenditures with respect to patients in public institutions for the mentally retarded to be the four quarters immediately preceding the quarter in which the State elects to provide such services under title XIX. The committee limited this maintenance of effort requirement to the first three years the program is in effect under title XIX (the requirement would expire December 31, 1974 under the committee amendment) because the basic purpose of such maintenance of effort requirements is to assure against wholesale reductions in State effort with the introduction of Federal dollars at the outset of a program and not to provide a perpetual obligation to continue expenditures at or above some previous historic level which has no relationship to later circumstances. The committee expects that the maintenance of effort provision will be implemented in a manner which will not impede the relocation and transfer of persons in public institutions for the mentally retarded to non-institutional community settings, and between institutions in the State.

Training of Intermediate Care Facility Administrators

(Sec. 296 of the bill)

Until July 1, 1972, medicaid funds supported State training programs for waived nursing home administrators designed to remove deficiencies in the qualifications of the administrators which would have otherwise prevented them from meeting State licensure requirements.

Public Law 92-223 authorized the transfer of the title XI intermediate care facility program to the title XIX program making possible the provision of ICF care as an optional service under a State medicaid plan. It also provided the Secretary with authority to set standards for ICF's. The committee has been advised by the Department that the ICF regulations to be issued by the Secretary will include standards for administrators of ICF's, and that a substantial portion of the administrators now operating ICF's may be unable to meet these standards.

The committee has therefore authorized expenditure of funds under title XIX for the two-year period ending June 30, 1974 to provide for supplemental training of ICF administrators who are unable to meet such standards as may be established in regulations by the Secretary.

Intermediate Care Services in States Which Do Not Have a Medicaid Program

(Sec. 292 of the bill)

Title XIX provides for Federal matching for medical services provided to low-income persons through State Medicaid programs. States were required to have Medicaid programs in effect as of January 1, 1970 or they could no longer receive Federal matching for medical vendor payments. To date, 52 jurisdictions have established programs under title XIX. Arizona and Alaska have not, as yet, chosen to participate in the program.

In 1967, the Congress made provision for Federal matching of payments for intermediate care facility services under title XI; as such, these payments were not considered to be medical vendor payments, and Federal matching was available independently of whether the State also had established a title XIX program. Public Law 92-223, provided, effective January 1, 1972, for the transfer of the intermediate care facility program to title XIX, making possible the provision of ICF care as an optional service under a State Medicaid plan to both those eligible for cash assistance and the medically needy. Matching was no longer available for these services under the cash payment programs.

An unintended effect of P.L. 92-223 was to deny the possibility of Federal matching for intermediate care facility services in those States without Medicaid programs. Therefore the committee has added an amendment to the bill to allow matching for intermediate care facility services under title XI in those States which did not, on January 1, 1972 have in effect an approved State plan under title XIX. Thus section 1121 would continue to apply to States without Medicaid programs until the first day of the first month after January 1, 1972, that the State has in operation an approved State plan under title XIX.

Intermediate care facilities participating in a program in those States which do not have a title XIX program would be expected to meet the same basic standards prescribed by the Secretary for intermediate care facilities participating in the Medicaid program.

Deletion of the Maintenance of Effort Requirement for Care for Individuals Age 65 and Over in Mental Hospitals

(Sec. 295 of the bill)

Current Medicaid law restricts coverage of inpatient care in institutions for mental diseases to individuals 65 years of age or older who are otherwise eligible for Medicaid. Under the provisions of the original statute, Federal matching for these services was tied to a requirement that the fiscal effort of State and local governments for these services be maintained. Specifically, section 1903(b)(1) required that States make a showing satisfactory to the Secretary that total expenditures from Federal, State, and local sources for mental health services

(including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for a given quarter exceed the average of the total expenditures from such sources for such services for each quarter of the fiscal year ending June 30, 1965.

The committee believes that this maintenance of effort requirement has ceased to have any real effect because the base period for expenditures is now outdated. Continuation of the maintenance of effort requirement, even if updated, would not be desirable because it has fulfilled its basic purpose—to assure that there would not be substantial decreases in non-Federal effort with the introduction of Federal dollars for support of inpatient care for those 65 and older in institutions for mental diseases. The fiscal commitment of State and local governments to this health care area is now clearly established, and the possibility of a large-scale cut-back does not appear likely. The committee has, therefore, deleted the maintenance of effort requirement.

Disclosure of Ownership in Intermediate Care Facilities

(Sec. 299A of the bill)

Present legislation requires that information regarding the ownership of any facility participating as a skilled nursing home under medicaid be made available to the State licensing agency. Each person having a direct or indirect ownership interest of 10 percent or more in the home must be identified: in the case of those homes organized as a corporation, the identity of each officer and director of the corporation; and in the case of those homes organized as a partnership, the identity of each partner. Each facility is to report to the State agency any changes in the status of its ownership.

In the belief that standards for skilled nursing facilities under both medicare and medicaid should be uniform, the committee has provided elsewhere in this bill that this requirement should also be applied to skilled nursing facilities participating in the medicare program. Intermediate care facilities, not otherwise licensed as skilled nursing homes by a State, will make ownership information available to the Secretary of Health, Education, and Welfare.

Public Law 92-223 transferred the intermediate care facility program from title XI to title XIX effective January 1, 1972, and gave the Secretary authority to establish standards for intermediate care facilities.

Present law does not require disclosure of ownership of ICF's although these facilities have problems comparable to skilled nursing homes which disclosure is intended to help solve. The committee believes that it is desirable to have the disclosure of ownership requirement also apply to intermediate care facilities participating under medicaid and has approved an amendment to that effect.

4. PROVISIONS OF THE HOUSE BILL WHICH WERE DELETED BY THE COMMITTEE

Supplementary Medical Insurance Deductible

Under present law, a deductible equal to the first \$50 of expenses incurred by a beneficiary for services of the type covered under the

supplementary medical insurance program is payable by the beneficiary.

Recognizing that medical costs have risen considerably since the beginning of the medicare program, the House concluded that it would be appropriate to increase the supplementary medical insurance deductible to \$60 as of January 1, 1972.

The committee has deleted this provision (section 204) from the House bill. It is the committee's belief that the House provision does not take into account the fact that due to increased medical care costs, aged beneficiaries (according to the Department of Health, Education, and Welfare) are paying nearly as much out of pocket for medical care now as they were prior to medicare. The 20 percent coinsurance which they must pay—apart from any amounts in excess of medicare's "reasonable charge" determination—is being paid on substantially higher charges today than obtained in 1965. Finally, while it can be argued that deductibles and co-payments may deter unnecessary care, it may also be argued that such requirements can also serve to deter the seeking of necessary care. The committee believes that effective operation of the Professional Standards Review Organizations should serve to assure the medical necessity of services provided—an approach which appears preferable to imposing economic barriers to necessary as well as unnecessary care.

Limits on Payments for Skilled Nursing Home and Intermediate Care Facility Services

Section 225 of the House bill provided 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 would be limited to 105 percent of such costs for the same quarter of the preceding year. It would also authorize the Secretary by regulation, to increase the percentage to take account of increases in per diem costs which result directly from increases in the Federal minimum wage, or which otherwise result directly from provisions of Federal law enacted (or amendments to Federal law made) after the date of enactment of H.R. 1.

The committee shares the concern of the House over rising expenditures for skilled nursing home and intermediate care facility services which are due to rising costs or inappropriate utilization. However, it does not believe that section 225 would be an equitable or administrable method of achieving cost control.

The committee believes that section 225 is inconsistent with an upgrading of care in facilities which may result in additional costs for the facility. The provision would be difficult to administer and inequitable in that it does not take into account many uncontrollable expenses and places an arbitrary limit, unrelated to services rendered, on payments to a facility. Furthermore, the Professional Standards Review provision approved by the committee should assure proper utilization of long-term care facilities, and overtime should serve to effectively control costs for these services. In addition, the committee has approved an amendment which would require States to reimburse skilled nursing facilities and ICF's on a reasonable-cost related basis by July 1, 1974. The PSRO amendment, as well

as the requirement for a reasonable differential between average State-wide reimbursement rates for ICF and skilled nursing facility care, will also contribute to more equitable and rational payment for institutional care, while providing some control on cost increases.

The committee has therefore deleted the section from the House bill.

Determination of Reasonable Cost of Inpatient Hospital Services Under Medicaid and Maternal and Child Health Programs

Under 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, except on an experimental and demonstration basis.

Section 232 of the House-passed bill would allow States, generally, to develop their own methods and standards for reimbursement of the reasonable costs of inpatient hospital services, thereby giving them flexibility in working out payment arrangements with their hospitals. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

The possibility exists that section 232 may provide the opportunity for States to reimburse hospitals under medicaid at less than the cost of medicaid services, and the committee feels that this would be undesirable.

The committee has, therefore, deleted the section.

Coverage of Ptois Bars

Under medicare's supplementary medical insurance program, specific provision is made for the 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. The House bill would cover these devices in the same way as other supportive devices or appliances. No payment would be made for eyeglasses to which such devices may be attached. Based upon expert professional opinion that ptosis bars are generally ineffective and usually contraindicated, the committee has deleted the provision from the bill.

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. Some facilities have had difficulty obtaining such consultation, and where obtainable, the consultants have often been quite

expensive. To alleviate this problem, a provision was included in the House bill which would prohibit the Secretary from requiring provision of medical social services as a condition of participation for an extended care facility under medicare.

The committee bill would delete the House provision. Social services are potentially valuable in controlling and assuring proper utilization, since the social work personnel are primarily responsible for discharge planning. Just last year, subsequent to House approval of H.R. 1, the Joint Commission on Accreditation established a requirement that hospitals have social service units designed to facilitate discharge planning. Removal of the requirement to provide such services would not be in the best interests of either the medicare program or its beneficiaries.

Requirements for Nursing Home Administrators

Present law provides that a skilled nursing home which is receiving medicaid payments must be operating under the supervision of an administrator licensed by the State agency or board whose purpose it is to develop, impose, and enforce standards regarding the qualifications and training of individuals applying for such a license. The current provision also permits the appropriate State agency or board to grant a waiver with respect to any of its standards to individuals who served as an administrator for the calendar year immediately preceding the calendar year in which the requirements for a licensure program were first met by the State provided there is a training program operating in the State to enable individuals to meet the requirements necessary to obtain a license. The waiver authority, however, expired on June 30, 1972.

The House was concerned that persons who have worked as nursing home administrators should not be precluded from serving in this capacity because they fail to meet certain statutory requirements of the medicaid program. The House therefore amended present law to permit States to grant a permanent waiver from title XIX requirements for licensure to those individuals who served as nursing home administrators for the three-year period preceding the year the State established a licensure program.

The Finance Committee approved the licensure provision in 1967 as a means of upgrading the quality of personnel administering nursing homes. The committee believes that a permanent waiver in regard to licensure requirements would be inconsistent with and possibly detrimental to assuring patient care of proper quality and the emphasis on the professional upgrading of nursing home standards.

The committee has therefore deleted this provision (section 269) from the bill.

Termination of the National Advisory Council on Nursing Home Administration

Included in the Social Security Amendments of 1967 was a provision for the establishment of a National Advisory Council on

Nursing Home Administration whose purpose was to study, develop, and advise the Secretary of Health, Education, and Welfare and the States on issues related to qualifications, training, and licensure programs of nursing home administrators. The Council was scheduled to terminate on December 31, 1971.

After reviewing the operation of the Council, and since the Council had completed its work at a date earlier than that provided by statute, the committee included a provision in H.R. 17550 providing for termination of the Council as of December 31, 1970. The House included a similar provision (section 270) in H.R. 1. However, the Council expired by statute on December 31, 1971, and the amendment terminating the Council is now unnecessary.

5. ADDITIONAL MATTERS OF CONCERN TO THE COMMITTEE

Coordination of Regulatory Activities for Clinical Laboratories

At present, the Department of Health, Education, and Welfare regulates laboratory operations and performance under two different programs—the medicare program, administered by the Social Security Administration, and the program for regulating laboratories engaged in interstate commerce, administered by the Center for Disease Control of the Health Services and Mental Health Administration. The two Federal programs issue separate regulations, apply different standards, and are administered by different personnel. However, the committee has been informed that efforts have been undertaken by the Department to coordinate the activity of its components with respect to regulation of clinical laboratories.

In order to try to eliminate the dual operation in favor of a single approach, the committee expects that the Secretary of Health, Education, and Welfare will continue to initiate such administrative changes as might result in uniform standards and policies and the placing of responsibility for regulating interstate laboratories in one organizational component of the Department. The committee also expects that the Secretary will report to it not later than 6 months after enactment, concerning the changes initiated, and that he will recommend such legislative action, if any, which may be required to avoid duplication.

Outpatient Physical Therapy in Rural Communities

Under present law outpatient physical therapy services are covered under medicare only when furnished by participating hospitals, extended care facilities, home health agencies, clinics, rehabilitation agencies, and public health agencies. The participating provider may furnish outpatient physical therapy through employees or by making suitable arrangements for self-employed physical therapists to work under its supervision. Payment is permitted for services in a self-employed therapist's private office only where the participating organization is a public health agency and neither it nor the other participating providers in the area are able to furnish a full range of physical therapy procedures on an outpatient basis. This approach was adopted be-

cause of the probability that participating organizations which provide none of the services themselves would not be able to adequately supervise the services independent practitioners perform in their private offices. An exception was made in the case of public health agencies because they represent the only participating provider in many rural areas and they often are not able to provide physical therapy on their premises. These agencies have no choice but to rely on a local independent practitioner and his facilities to provide physical therapy to their patients.

While the committee supports this policy, it has come to the committee's attention that there are also some rural communities where the only participants in the medicare program are hospitals which do not provide physical therapy on their premises. The committee believes that the Secretary should accord such hospitals the same treatment accorded to public health agencies in order to assure that covered outpatient physical therapy is available to beneficiaries in these rural areas. The committee understands that some rural hospitals have already arranged for necessary physical therapy services to be provided to beneficiaries off their premises but in the community served by the hospital. If he has not already done so, it expects that the Secretary will validate such arrangements where they were reasonable under the circumstances.

Qualification of Home Health Agency

One of the statutory requirements for participation in medicare as a "home health agency" is that the agency must be "primarily engaged in providing skilled nursing services and other therapeutic services." It has come to the committee's attention that this requirement has been interpreted to mean that an agency which has only nurses on its staff may not participate in medicare as a home health agency even though the nurses may perform services in addition to nursing. In the committee's view, a home health agency which provides skilled nursing and other therapeutic services should not be disqualified from participating solely on the ground that it employs only skilled nurses to provide such services. The committee expects that the Secretary will take this view into account in determining an agency's eligibility to participate in medicare and medicaid as a home health agency.

Home Health Services

Home health services are presently covered under medicare only if they are provided by a qualified home health agency under an overall plan of treatment prescribed by a physician for a beneficiary who has a need for such services. Although there is no requirement that the coverage of home health services under medicaid be similarly limited; in fact the same requirements have also been applied. However, in some rural areas and small towns there are no home health agencies and only a few physicians to provide services over broad geographical areas. Some physicians in these areas call upon nurses to provide certain serv-

ices to homebound patients. Such services could be covered as "home health services" if provided by a qualified home health agency or as services "incident to a physician's service" where the physician actually accompanied the nurse. These services are, of course, services which the nurse is licensed to perform. In the absence of a home health agency, the only way they now may be paid for under medicare is for the physician to perform such services himself or to accompany his nurse to the patient's home.

The committee believes that these alternative arrangements for payment represent a highly uneconomical use of scarce physician manpower. The Secretary of Health, Education, and Welfare should waive the normal requirements with respect to coverage of health services performed in the patient's home, so as to cover certain added services where: (1) the service was individual or intermittent; (2) the service was rendered by a nurse or trained technician employed or engaged (under arrangements acceptable to the Secretary) by a visiting nurse association or similar organization or by a physician; (3) the service of such a professional was required for the care of the patient; (4) there was either no participating home health agency servicing the area or none servicing the area which could provide the service in a timely fashion; (5) the cost to the program is probably less than it would have been had the service been performed incident to a physician's services; and (6) the service is ordinarily provided in a manner which the Secretary finds appropriate. The Committee expects that similar services would also qualify for reimbursement as home health services under the medicaid program.

The committee suggests that the services covered by the waiver be limited to those services which could be covered if performed as a regular home health service or incident to a physician's service. Payment would be made at no more than the reasonable charge or reasonable cost, as appropriate, for such services.

MEDICAID BENEFIT COST ESTIMATES UNDER CURRENT LAW AND SENATE VERSION OF H.R. 1, CALENDAR YEARS 1973-77

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, the following statement, provided by the Department of Health, Education, and Welfare, is made relative to the costs incurred in carrying out the medicaid provisions of this bill. With the exception of the item noted on the projected costs and savings, the committee and the Department reasonably agree.

1. Base program costs for medicaid are derived from estimates of medical vendor payments, projected from the base of the fiscal year 1973 expenditures contained in the President's budget, and adjusted to reflect the inclusion of services in intermediate care facilities (transferred from title XI to title XIX, effective January 1, 1972). Three basic factors influence the estimates of title XIX costs over the 5-year period: inflation in medical care costs, growth in the eligible population (generally reflecting the increase in the cash assistance population), and changes in patterns of utilization. The rates of inflation assumed vary somewhat by type of service; they are in line with the

policies of the wage-price guidelines, and parallel those used by the Social Security actuaries in estimating future costs under title XVIII.

2. The current law estimate is based on assumptions of continuation of current programs for cash assistance for families and needy adults, and continuation of current medicaid. The estimates are based on assumptions of slightly increased use of noninstitutional services in response to program policies and initiatives planned over the 5-year period.

3. Estimates of the impact of the Senate version of H.R. 1 account only for the impact of the title II provisions. Offsets occurring under title XIX because of changes in title XVIII coverage have been included. It should be noted, however, that the impact of extending medicaid to employment program families (who are ineligible under the terms of the current program because of the presence of an employed father in the home) have not been included, because they are more properly reflected as a cost resulting from title IV of the bill. Similarly, no estimate has been prepared of the impact of the provision for treatment of alcoholics and addicts under title XV of the Social Security Act. In general, the cost implications of that provision will consist of transfers from one program (in this case title XIX) to another, the title XV program.

4. It should be noted that the cost estimates of the Senate version of H.R. 1 are not directly comparable to similar estimates of the impact of the House version on H.R. 1. This is the result of several factors:

(a) The projections of program costs prepared in conjunction with the House version of H.R. 1 were derived from a slightly different base than was used for estimating purposes for the Senate bill. This reflects the fact that the estimates prepared in conjunction with the Senate version of H.R. 1 were prepared nearly one full year later, and more recent data were available upon which to base program estimates. The projection of current program costs prepared in conjunction with this bill are therefore more recent and more accurate.

(b) The base figures used for preparation of estimates for this bill included expenditures for intermediate care facilities, reflecting the transfer of this service to title XIX.

(c) The 20 percent increase in social security benefits recently enacted into law caused some reduction in the size of the population eligible for medicaid, and lowered slightly the base of medicaid expenditures.

(d) The estimates prepared in conjunction with the House bill were fiscal year figures. The figures accompanying this bill are on a calendar year basis.

(e) The figures prepared in conjunction with the Senate bill represent total title XIX expenditures (medical vendor payments and administrative costs). The estimates prepared in conjunction with the House bill represented medical vendor payments only; administrative costs were not included. In general, administrative costs are approximately 5 percent of medical vendor payments under title XIX.

(f) The effective dates of many of the provisions in the Senate bill are later than those contained in the House bill. This accounts for a substantial difference in the estimate of the impact of the two bills in the initial years.

IMPACT OF SENATE VERSION OF H.R. 1 ON FEDERAL MEDICAID
COSTS, CALENDAR YEARS 1973-77

[Millions of dollars]

	Federal fiscal impact	
	Calendar year 1973	1974
Section (from House bill):		
201 Coverage of disabled under medi- care.....	-30	-67
207 Comprehensive health care.....	-74	-162
208 Cost sharing under medicaid.....	-62	-62
209 Determination of payments.....	+79	+29
231 Maintenance of effort.....	¹ -570	¹ -640
271 Increased matching to Puerto Rico...	+10	+10
New provisions:		
Drugs under medicare.....	-24	-51
Coverage of mentally ill children.....	+52	+120
Level of care requirements.....	-13	-14
75 percent matching on contract medical personnel.....	+5	+6
100 percent reimbursement-SNH in- spectors.....	+19	+21
Reasonable cost related reimbursement.....		+17
Total Federal fiscal impact.....	¹ -608	¹ -793

¹ The committee does not agree with the Department concerning the estimate of savings. Because of the substantial savings accruing to States under various provisions of the bill, the committee does not anticipate any wholesale cutbacks by States in their medicaid programs. The purpose of the amendment involved was to permit States to make orderly (and often short-term) adjustments in their medicaid programs from time to time as circumstances dictated. Thus, the calendar year 1973 total of savings should be reduced by about \$500,000,000 and that for 1974 by some \$600,000,000.

MEDICAID COST ESTIMATES, CURRENT LAW AND SENATE
VERSION OF H.R. 1, CALENDAR YEARS 1973-77

[Millions of dollars]

Calendar year	1973	1974	1975	1976	1977
Current law.....	5,655	6,559	7,542	8,579	9,674
H.R. 1, Senate version.....	5,047	5,766	6,679	7,609	8,593
Federal savings.....	¹ 608	¹ 793	¹ 863	¹ 970	¹ 1,081

¹ Committee does not agree. See footnote on preceding table.

V. FINANCING OF SOCIAL SECURITY TRUST FUNDS

Financing of Social Security Trust Funds

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V. FINANCING OF SOCIAL SECURITY TRUST FUNDS

A. Financing Provisions

Consistent with the policy of maintaining the social security program on a financially sound basis, which has been followed in the past, the committee bill would make provision for meeting the cost of the expanded program under the bill. To meet the cost of the improvements in the cash benefit programs and the extension of medicare coverage to disabled beneficiaries and to include drug coverage, the schedule of tax rates would be revised as shown in table 1 below. Under both present law and the committee bill, the limitation on wages taxable under social security would be increased from \$9,000 in 1972 to \$10,800 in 1973, to \$12,000 in 1974, and starting in 1975 the limit would rise as average wages increase.

TABLE 1.—SOCIAL SECURITY TAX RATES FOR EMPLOYERS EMPLOYEES, AND SELF-EMPLOYED PERSONS UNDER PRESENT LAW AND COMMITTEE BILL

[In percent]

	Employer and employee, each			Self-employed		
	OASDI	HI	Total	OASDI	HI	Total
Present law:						
1972.....	4.6	0.6	5.2	6.9	0.6	7.5
1973.....	4.6	.9	5.5	6.9	.9	7.8
1974 to 1977.....	4.6	.9	5.5	6.9	.9	7.8
1978 to 1985.....	4.5	1.0	5.5	6.7	1.0	7.7
1986 to 1992.....	4.5	1.1	5.6	6.7	1.1	7.8
1993 to 2010.....	4.5	1.2	5.7	6.7	1.2	7.9
2011 and after.....	5.35	1.2	6.55	7.0	1.2	8.2
Committee bill:						
1972.....	4.6	.6	5.2	6.9	.6	7.5
1973 to 1977.....	4.9	1.1	6.0	7.0	1.1	8.1
1978 to 1980.....	4.95	1.3	6.25	7.0	1.3	8.3
1981 to 1992.....	4.95	1.5	6.45	7.0	1.5	8.5
1993 to 2010.....	4.95	1.6	6.55	7.0	1.6	8.6
2011 and after.....	6.05	1.6	7.65	7.0	1.6	8.6

B. Social Security Cash Benefit Programs

ACTUARIAL ASSUMPTIONS USED BEFORE 1972

The financing of the social security cash benefit programs has always been carefully considered by the Congress with a view toward ensuring the actuarial soundness of the old age, survivors and disability insurance system. Actuarial soundness has meant that the estimated future income from contributions and interest earnings on the accumulated trust fund investments would over the next 75 years pay for the expenditures for benefits and administrative expenses.

The long-range estimates for the social security cash benefit programs have until now been based on the assumption that earnings and benefit levels would not change over the next 75 years. This does not mean that covered payrolls were assumed to be the same each year; rather, they were projected to rise steadily as the covered population at the working age was expected to increase.

The assumption that neither wages nor prices would increase in the future was not meant as an economic forecast but rather as a purposefully conservative assumption on which to base a measure of the long-range cost of the program and proposed changes in the program. The assumptions recognize the probability that wage levels will continue to rise in the future and that Congress will act to increase benefits. Moreover, because of the conservative nature of the assumptions, when the costs are expressed in terms of a percentage of payroll, they allow for an increase in benefit levels in proportion to any rise in wage levels that actually does occur. In fact, as earnings levels and prices have actually increased, actuarial surpluses accumulated which could be and were used to finance a part of the cost of further benefit increases. Along with the periodic congressional action to increase benefits, the tax rates for the short-range future were generally adjusted to prevent a large accumulation of trust funds. These adjustments have generally meant that in recent years the trust funds have had sufficient assets to pay for a little more than 12 months of current benefits, as shown in the table below. Thus as a practical matter, the legislation enacted by the Congress in the past decade has resulted in the social security program being operated on a pay-as-you-go basis.

TABLE 2.—INCOME AND OUTGO OF SOCIAL SECURITY CASH
BENEFIT TRUST FUNDS

[In billions of dollars]

Year	Income	Outgo	Net increase or decrease	Assets, end of year
1961.....	12.9	13.4	—0.5	22.2
1962.....	13.7	15.2	—1.5	20.7
1963.....	16.2	16.2	.....	20.7
1964.....	17.5	17.0	0.5	21.2
1965.....	17.9	19.2	—1.3	19.8
1966.....	23.4	20.9	2.5	22.3
1967.....	26.4	22.5	3.9	26.2
1968.....	28.5	26.0	2.5	28.7
1969.....	33.3	27.9	5.5	34.2
1970.....	37.0	33.1	3.9	38.1
1971.....	40.9	38.5	2.4	40.4

CHANGE IN ACTUARIAL ASSUMPTIONS

With the enactment of Public Law 92-336, the Congress adopted a schedule of tax rates which is based on a new set of actuarial assumptions. The new assumptions do not change the cost of the program; they merely change the way in which the cost is measured and consequently the tax rates scheduled in the law. The major modification is that the actuarial projections now assume an increase in both wages and prices in future years.

CONTRIBUTION RATE SCHEDULE FOR OLD-AGE, SURVIVORS, AND
DISABILITY INSURANCE IN THE COMMITTEE BILL

The contribution rate schedule for old-age, survivors, and disability insurance contained in the committee bill, as well as that under present law, is shown in table 3 below. The maximum earnings bases to which these tax rates are applied are the same under the committee bill as under present law—that is, \$9,000 for 1972, \$10,800 for 1973 and \$12,000 for 1974; thereafter, the base would rise automatically as average earnings rise.

TABLE 3.—TAX RATES FOR SOCIAL SECURITY CASH BENEFIT PROGRAMS, PRESENT LAW AND COMMITTEE BILL

[In percent]

Calendar year	Combined employer-employee rate		Self-employed rate	
	Present law	Committee bill	Present law	Committee bill
1972.....	9.2	9.2	6.9	6.9
1973 to 1977.....	9.2	9.8	6.9	7.0
1978 to 2010.....	9.0	9.9	6.7	7.0
2011 and after.....	10.7	12.1	7.0	7.0

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 of the law in effect at that time which authorized appropriations (if needed) 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 as nearly self-supporting as possible, on the basis of the best available actuarial projections.

ACTUARIAL SOUNDNESS OF THE 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 or private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of any given time, have enough assets to cover 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 have the same significance in a social insurance system as it does in a plan established under private insurance principles. In a social insurance system, unlike a private system, it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation in determining whether a social insurance system is in actuarial balance.

The old-age, survivors, and disability insurance program is actuarially sound if the estimated future income from contributions and from interest earnings on the accumulated contingency trust funds will, over the long-range period considered in the valuation, support all the system's expenditures. Obviously, future experience may be expected to vary from any 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 cost estimates being used, results in the system being in balance or substantially close thereto.

BASIC ASSUMPTION FOR COST ESTIMATES

General Basis for Long-Range Cost Estimates

The long-range estimates for the old-age, survivors, and disability insurance program presented in this report are based on the assumption that average earnings in covered employment will increase in the future at an annual rate of 5 percent. Similarly, the assumption has been made that the Consumer Price Index will increase at a constant annual rate of $2\frac{3}{4}$ percent. These two assumptions yield an implied increase in real earnings of $2\frac{1}{4}$ percent per year, which is close to the actual average experience of the last 20 years (however, the most recent experience would indicate a lower average value). In order to protect the financing of the system against possible future fluctuations in factors used in the cost estimate, a safety margin of $\frac{3}{8}$ of one percent has been added for every year after 1973 and up to the year 2010. It will be noted that the addition of this margin is approximately equivalent to an assumption that for the period 1974-2010, average real earnings will increase by $1\frac{7}{8}$ percent per year.

These long-range cost projections are based on assumptions that are intended to represent close to full employment. The aggregate amount of earnings taxable in 1973 under the scheduled base of \$10,800 is estimated at about \$557 billion. Similarly it is estimated that \$618 billion of earnings will be taxable in 1974 under the scheduled \$12,000 earnings base. The latter amount is projected to increase in the future as the covered population grows and as the average taxable earnings increase due to increases in the tax base as well as to increases in average earnings in covered employment.

The long-range cost estimate presented in this report was prepared for a 75-year period. A shorter period of valuation would not be appropriate because of the projected movement in the aged population. 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, a period extending beyond the year 2015 is needed to show the effect of a changing aged population on the cost of the social security cash benefit programs.

Measurement of Costs in Relation to Taxable Payroll

In general, long-range costs in this report are shown as a percentage of taxable payroll. This is the best measure of the long-range cost of the program. Dollar figures taken alone could be misleading. It should be recognized that cost projections based on assumptions of increasing wages and benefits involve the use into the distant future of geometric growth in economic factors, which would tend to make the resulting dollar figures difficult to relate to current dollar values.

General Basis for Short-Range Cost Estimates

The basis for the short-range cost estimates (shown for the individual years 1972-77) is similar to that used in the past and assumes that employment and earnings will increase each year. A gradual rise in the earnings level in the future (about 5-6 percent per year), somewhat below that which has occurred in the past few years, is assumed. Covered employment is assumed to increase by about 2.4 million workers per year during the period.

Average-Cost Concept

In the past an important measure of long-range cost has been the level-equivalent contribution rate required to support the system for 75 years, based on discounting at interest. Supporting the system includes not only meeting the benefit costs, the administrative expenses, and other expenditures, but also maintaining a reasonable contingency fund which at the end of the period amounts to one year's disbursements.

If the tax rate was actually set at this level rate for the next 75 years, relatively large accumulations in the trust funds would result, and there would eventually be a sizable income from interest. In practice, the Congress has set tax schedules with relatively lower rates in earlier years and higher rates in later years to avoid an unnecessary accumulation of funds in the early years. But the concept of level-premium costs is a convenient way to measure long-range costs and might also be used with the new cost estimate assumptions. In fact, such a concept might be simplified by an approximation in the case of the new assumptions. The Social Security Administration Actuary informed the committee that it can be shown that if the discount interest rate assumed in the level-cost is not too different from the rate of growth of the taxable payroll assumed, the level-cost concept could be approximated by the simple arithmetic averaging of the annual costs as percent of payroll. It is believed that this simplified average-cost concept does not depart significantly from the level-cost values that have been used in the past. As an example, it is estimated that for the social security cash benefit programs under present law, the average-cost computed over the next 75 years is 9.77 percent of taxable payroll, which is comparable to the level-cost of 9.79 percent of taxable

payroll. On the same basis the average future tax rate is 9.84 percent of taxable payroll while the level-equivalent tax rate is 9.87 percent of taxable payroll. The actuarial balance would be +0.07 percent of taxable payroll under the average-cost concept as compared to +0.08 percent of taxable payroll under the level-cost concept.

Interrelationship With Railroad Retirement System

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These amendments provided for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining retirement and disability benefits for workers with less than 120 months of railroad service and also for all survivor cases.

Financial interchange provisions were established so that the Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund are 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.

ACTUARIAL BALANCE OF THE PROGRAM IN PAST YEARS

Actuarial Balance of the Program After Enactment of P.L. 92-5

The social security changes in P.L. 92-5 approved in March 1971 contained a 10 percent 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 tax rates going into effect after 1975. 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 were within acceptable limits of variation.

Actuarial Balance of the Program After Enactment of P.L. 92-336

The social security changes in P.L. 92-336 enacted in July 1972 contained a 20 percent benefit increase effective for the month of September 1972. In addition the earnings base was increased to \$10,800 for 1973 and to \$12,000 for 1974 and both the benefits and the earnings base are to be automatically adjusted thereafter. After these changes, as measured under the new methodology, the program is in close actuarial balance. The old-age, survivors, and disability insurance program has an actuarial balance of +0.07 percent of taxable payroll.

ACTUARIAL BALANCE UNDER THE COMMITTEE BILL

Table 4 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 4.—CHANGES IN ACTUARIAL BALANCE OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED AVERAGE-COST AS PERCENT OF TAXABLE PAYROLL, BY TYPE OF CHANGE, LONG-RANGE DYNAMIC COST ESTIMATES, PRESENT LAW AND COMMITTEE BILL

[In percent]

Item	OASDI system
Actuarial balance of present system.....	+0.07
Age 62 point for men (prospective).....	— .22
Earnings test changes.....	— .28
Widow's benefits of 100 percent PIA at 65.....	— .24
Special \$200 minimum benefit.....	— .14
Delayed retirement increment.....	— .09
4-month disability waiting period.....	— .09
Liberalized disability benefits for blind.....	— .09
Miscellaneous changes ¹	— .03
Revised contribution schedule.....	+1.12
Total effect of changes in bill.....	— .06
Actuarial balance under bill.....	+ .01

¹ Includes the following: Workmen's compensation offset based on 80 percent of highest earnings; child's benefits to children disabled at ages 18 to 21; disabled child 7 years reentitlement; broaden definition of adopted child; student's benefits to end of semester of attainment of age 22; child's benefits on grandparent's account if supported by him and both parents are disabled or deceased; benefits to dependent sister and dependent disabled brother; elimination of support requirement for divorced wife's and widow's benefits; and reduced widower's benefits at age 60.

The changes made by the committee bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance program. The system would be close to being in exact actuarial balance. There would be a negligible actuarial surplus of +0.01 percent of taxable payroll.

Under the tax schedule recommended by the committee the old-age, survivors, and disability insurance trust funds would decrease to about 75 percent of the following year's outgo by 1977; thereafter the funds would grow slowly towards 100 percent of the following year's outgo.

AVERAGE-COST OF BENEFIT PAYMENTS BY TYPE

The average-cost of the old-age, survivors, and disability insurance benefits (excluding the cost of administrative expenses, the railroad

retirement financial interchange and the effect of the size of the fund) under the present law is 9.50 percent of taxable payroll. The corresponding figure for the program as modified by the committee's bill would be 10.66 percent of taxable payroll.

Table 5 presents the average-cost by type of benefit for the program as it would be modified by the committee bill.

TABLE 5.—ESTIMATED AVERAGE-COST BY TYPE OF BENEFIT PAYMENT, ADMINISTRATIVE EXPENSES, RAILROAD RETIREMENT FINANCIAL INTERCHANGE, AND EFFECT OF THE FUND SIZE FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS MODIFIED BY THE COMMITTEE BILL, AS PERCENT OF TAXABLE PAYROLL, LONG-RANGE DYNAMIC COST ESTIMATE

[In percent]	
Item	OASDI
Primary benefits.....	7.60
Wife's and husband's benefits.....	.57
Widow's and widower's benefits.....	1.34
Parent's benefits.....	.01
Child's benefits.....	.94
Mother's benefits.....	.13
Lump-sum death payments.....	.07
Total benefits.....	10.66
Administrative expenses.....	.21
Railroad retirement financial interchange.....	.05
Size of existing trust fund.....	.03
Net total average-cost.....	10.95

INCOME AND OUTGO IN NEAR FUTURE

Under the committee bill, benefit disbursements under the old-age survivors, and disability insurance program would increase by about \$3.3 billion over present law in 1974, the first full calendar year of operation under the modified program. The contribution income for the old-age, survivors, and disability insurance program in 1974 would be about \$3.5 billion higher than under present law (see Table 6). The estimates in Table 6 are based on an assumption that the automatic adjustment provisions in present law will result in general benefit increases of 5.1 percent in 1975 and 5.5 percent in 1977, while the taxable earnings base would be increased to \$12,600 in 1975 and to \$14,100 in 1977.

TABLE 6.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS,
COMBINED, CALENDAR YEARS 1965-77

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contri- butions ¹	Interest on fund	Benefit payments ²	Adminis- trative expenses	Railroad retirement financial interchange		
Past experience:							
1965.....	\$17,205	\$651	\$18,311	\$418	\$459	-\$1,331	\$19,841
1966.....	22,679	702	20,051	393	469	2,467	22,308
1967.....	25,518	896	21,417	515	539	3,942	26,250
1968.....	27,448	1,045	24,954	603	458	2,479	28,729
1969.....	32,004	1,342	26,767	612	513	5,453	34,182
1970.....	35,202	1,791	31,884	635	589	3,886	38,068
1971.....	38,880	2,027	37,199	719	626	2,366	40,434

**Estimated future experience
under committee bill:³**

1972.....	43,925	2,238	41,608	877	749	2,929	43,363
1973.....	52,914	2,308	52,530	886	829	977	44,340
1974.....	59,135	2,472	55,588	916	1,000	4,103	48,443
1975.....	63,837	2,746	60,802	959	1,067	3,755	52,198
1976.....	67,335	2,998	63,866	1,002	1,069	4,396	56,594
1977.....	72,847	3,184	70,202	1,045	1,085	3,699	60,293

¹ Includes reimbursements from general fund of Treasury for costs of noncontributory credits for military service and payments to noninsured persons aged 72 and over.

² Includes payments for vocational rehabilitation services.

³ Based on a contribution rate of 4.9 percent for employer and employee, each, in the calendar years 1973-77, and a contribution and benefit base of \$10,800 in 1973 and \$12,000 in 1974. Under the automatic increase provisions, the following changes are assumed to occur on January 1 of the stated years:

Year	General benefit increase (percent)	Contribution and benefit base
1975.....	5.1	\$12,600
1977.....	5.5	14,100

Under the program as modified by the committee bill, the old-age, survivors, and disability insurance trust funds would increase slowly between 1972 and 1977, rising from \$43 billion to \$60 billion. However, as a percentage of the following year's outgo, the funds would remain relatively constant at about 77-78 percent.

Long-Range Projection of OASDI "Current Cost"

Table 7 shows the estimated "current cost" of the old-age, survivors, and disability insurance program under the committee bill as percent of taxable payroll for various future years.

TABLE 7.—ESTIMATED "CURRENT COST"¹ OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL,² UNDER COMMITTEE BILL, LONG-RANGE DYNAMIC COST ESTIMATE,³ FOR SELECTED YEARS, 1980 TO 2045

[In percent]

Calendar year	OASDI "current cost" ¹
1980.....	9.90
1985.....	9.72
1990.....	10.08
1995.....	9.71
2000.....	9.49
2005.....	9.55
2010.....	10.16
2015.....	10.89
2020.....	11.74
2025.....	12.33
2030.....	12.55
2035.....	12.57
2040.....	12.63
2045.....	12.80
Average cost ⁴	10.95

¹ Represents the cost as percent of taxable payroll of all expenditures in the year, including amounts needed to maintain the funds at about the following year's expenditures.

² Payroll is adjusted to take into account the lower contribution rate on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

³ Under the dynamic assumptions, the average taxable earnings and the taxable earnings base are assumed to increase at a rate of 5 percent per year, while the benefit table is subject to annual increases of 2¾ percent according to increases in CPI. In addition, a margin of ⅓ of 1 percent is added for every year after 1973 and before the year 2011.

⁴ Represents the arithmetic average of the "current cost" for the 74-year period 1973 to 2046 and includes the effect of the fund ratio at the end of 1972.

The above projection is based on the assumption that no future changes in the system will be enacted. However, benefits are subject to the automatic cost-of-living adjustment and under the assumptions used, the average benefit will increase in the future at a lower rate than taxable earnings.

According to this projection, the "current-cost" of the Old-Age, Survivors, and Disability Insurance Program as a percentage of taxable payroll will be almost flat for about the next four decades. Thereafter, the cost as a percentage of taxable payroll would tend to increase.

C. Actuarial Cost Estimates for the Hospital Insurance System

SUMMARY OF ACTUARIAL COST ESTIMATES

The hospital insurance system, as modified by the committee bill, has an actuarial balance of +.01% of taxable payroll. The small size of this balance indicates that future income and future outgo are in close balance and that the system is actuarially sound, according to the assumptions used.

It should be noted, however, that this balance is based on an actuarial methodology somewhat different from that employed in past reports of this committee and in the annual reports of the Board of Trustees of the hospital insurance program before 1972. The new methodology, however, produces approximately the same balance. The new methodology employed is the same as that endorsed by the Board of Trustees in their 1972 annual report, for a system which includes an automatic adjustment of the taxable wage base.

The only change in actuarial methodology from that previously used lies in the adoption of the average of current costs ratios as the criterion of actuarial balance, rather than an interest discounted level cost calculation. Dynamic assumptions both as to income and outgo have always been used for the hospital insurance program by the Administration. Since 1970, it has also been assumed that the wage base would be adjusted to reflect the average increase in earnings in employment covered by Social Security; Public Law 92-336 explicitly provided for such adjustment. The derivation, however, of the actuarial balance from these calculations is different than previously used, although the results are approximately the same as resulted from the previous methodology.

The assumptions employed are consistent with those underlying the cost estimates contained in the 1972 Annual Report of the Board of Trustees for the Hospital Insurance Program. A detailed analysis of the methodology and a summary of the principal actuarial assumptions used appears in the actuarial appendix to the Trustees report.*

SUMMARY OF COMMITTEE ACTIONS WHICH HAVE A SUBSTANTIAL IMPACT ON THE COST OF THE PROGRAM

1. Extension of the Hospital Insurance System to the Disabled

The most important change in the hospital insurance system provided for in the committee bill is the extension of the system to disabled workers under age 65 who have been entitled to benefits under the disability insurance system for no less than 24 consecutive months; and to disabled widows, dependent widowers, and beneficiaries entitled to child's benefits based on disability which began prior to age 22 who

* (See page 359.)

have been entitled to cash benefits for no less than 24 consecutive months.

The committee bill also includes under the hospital insurance program several new categories of persons eligible for disability insurance benefits beginning in January 1973, who are not covered under the House version of the bill. When these beneficiaries have been on the rolls 24 consecutive months, they will be eligible for hospital insurance coverage, and paying benefits to them will increase the cost of this provision in subsequent years.

The committee has also increased the number of beneficiaries eligible for hospital insurance benefits by reducing the waiting period from 6 to 4 months (which results in hospital insurance benefits beginning after the 28th consecutive month of disability) and extended coverage to the month following termination for those recovering from disability.

The estimated cost for the extension of the HI system to the disabled in 1974 is \$1,412 million, including \$6 million to cover certain widows over age 50 who are collecting mother's benefits, but who could qualify for disabled benefits if they chose to apply.

Estimating the cost for hospitalization and related benefits for a disabled population is more difficult than estimating the cost for similar benefits for those age 65 and over, since there is no program data from which to establish a reliable basis for forecasting future experience. Consequently, the estimates provided for the cost of this provision are not as reliable as those for the regular benefits covered under the program.

2. Coverage of Specific Prescription Drugs for Specified Chronic Conditions

A major change in the coverage provided by the hospital insurance system is the extension of the benefits provided for both aged and disabled to include the cost of specific prescription drugs which are normally prescribed for specified chronic conditions, subject to a \$1 copayment. Coverage is to begin on July 1, 1973. The estimated cost in 1974 is \$740 million.

Estimates as to the cost of this provision are necessarily less reliable than the cost estimates for benefits already provided under the hospital insurance program. Further, the cost of the provision will depend partially on the determinations of the National Formulary Committee established by the provision in establishing the specific drugs that will be covered and the allowances that the Secretary of Health, Education, and Welfare determines will be paid for covered drug items.

3. Liberalization of Rehabilitation Services Covered in Extended Care Facilities and in Home Health Agencies

The committee bill extends the coverage provided for skilled rehabilitation services in extended care facilities and in home health agencies to include rehabilitative services provided on a regular daily basis to patients who may not require skilled nursing care on a regular basis but who do need the skilled rehabilitation services in the skilled facility. The requirements relating to the institution in which coverage is provided will remain the same as at present. 1974 cost: \$110 million.

4. *Waiver of Beneficiary Liability for Disallowed Claims*

The committee bill provides for the waiver of beneficiary liability (and in some instances the liability of the provider) where the claim for reimbursement to the provider has been disallowed retroactively as an unnecessary service, custodial care, or otherwise noncovered care if the beneficiary did not know or had no reason to know such services or care was involved. Provision is also made to reimburse such claims that have been disallowed in previous years from July 1, 1971. 1974 cost:

\$85 million.

5. *Reduction of Copayment on Lifetime Reserve Days*

The committee bill reduces the copayment on lifetime reserve days from $\frac{1}{2}$ of the inpatient deductible to $\frac{1}{4}$ of the inpatient deductible. 1974 cost: \$79 million.

The committee did not adopt two provisions included in the House bill which provided for the introduction of a copayment provision equal to $\frac{1}{8}$ of the hospital insurance deductible applicable from the 31st to the 60th day of hospitalization and to increase the number of lifetime reserve days from 60 to 120 days.

It should be noted that some of the increases in benefits provided will have much larger cost in the future than in 1974, especially those which liberalize the requirements to draw benefits under the disabled insurance program.

PROVISIONS REDUCING THE COST OF THE PROGRAM

The committee bill also contains a number of additional 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 customer charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. These provisions will require several years to become fully effective.

The committee bill also contains provision that would eliminate payments under the medicare program for services covered by the Federal Employees Health Benefits Plan, beginning in 1975, unless such plan is modified to make available coverage supplementary to that under the medicare program. The actuarial cost estimates do not take any possible reduction in benefit payments into account due to the likelihood that such modification will occur.

Another major change made by the bill is to revise the reimbursement mechanism applicable to covered services received by individuals who obtain medicare coverage through a health maintenance organization (HMO). HMO's which participate on a risk-sharing basis will receive reimbursement for services provided to hospital and medical insurance beneficiaries on a prospective capitation basis, but with

retroactive adjustments which share any savings to the HMO (resulting from its achievement of lower costs per capita than the actuarial equivalent cost per capita outside the HMO) or any corresponding loss between the HMO and the trust fund. The basis for such prospective capitation rate and for the determining and allocating of any savings or loss is explained elsewhere in this report. Since the decision to participate on a risk-sharing basis lies with the HMO, it is assumed that relatively more organizations which will be able to achieve savings will participate than those which will incur losses. Since the organizations which elect to participate on a risk-sharing basis would have otherwise been reimbursed at cost, there will be an excess of savings over losses and thus an increase in reimbursement under the program. Over time however, to the extent that a larger proportion of beneficiaries enroll in HMO's which are able to provide services more economically, there may be a reduction in reimbursement. No valid experience is available to estimate the possible extent of long-run savings.

Several other provisions should have a significant impact in reducing the cost of the program in the longrun and to an unknown extent in the short-run but for which adequate data upon which to project estimated savings are not available. The most significant of these cost saving provisions is the establishment of professional standards review organizations, which would evaluate and determine the medical necessity of all institutional and out-of-institution care for purposes of eligibility for program payment as well as to provide for the review of the quality of care. Significant savings have been achieved by prototype professional standards review organizations.

Other potential cost-saving provisions include the limitation on the Federal participation in payment for disapproved capital expenditures and the authority to the Secretary to reassign providers to intermediaries.

CONTRIBUTION RATE SCHEDULE FOR HOSPITAL INSURANCE IN THE COMMITTEE BILL

The schedule of contribution rates for the hospital insurance program under present law and under the committee bill are shown below. The maximum earnings base to which these rates are applied is \$10,800 in 1973, \$12,000 in 1974 and adjusted automatically thereafter.

TABLE 8.—HOSPITAL INSURANCE TAX RATES UNDER PRESENT LAW AND UNDER COMMITTEE BILL

Calendar year	[In percent]			
	Combined employer-employee rate		Self-employed rate	
	Present law	Committee bill	Present law	Committee bill
1973 to 1977	1.8	2.2	0.9	1.1
1978 to 1980	2.0	2.6	1.0	1.3
1981 to 1985	2.0	3.0	1.0	1.5
1986 to 1992	2.2	3.0	1.1	1.5
1993 to 1997	2.4	3.2	1.2	1.6

LONG RANGE COST ESTIMATES

The tax rates specified in the bill are set according to the "current cost" of the program, i.e., the ratio of (i) the sum of benefit payments and administrative expenses for insured persons, and an allowance for trust fund growth proportional to the size of the program to (ii) the effective taxable payroll. The tax rates for the early years are enough higher than such current cost rates to allow the trust fund to grow to the level of 75 percent of the next year's expenditures by 1977. The committee believes that this method will provide sound financing for the hospital insurance program. The current cost rates for the committee bill and according to present law, are shown in the table below.

TABLE 9.—CURRENT COST RATES FOR HOSPITAL INSURANCE
UNDER PRESENT LAW AND COMMITTEE BILL

[In percent]

Year	Present law	Committee bill
1973.....	1.54	1.91
1974.....	1.61	2.16
1975.....	1.71	2.31
1980.....	2.01	2.71
1985.....	2.12	2.86
1990.....	2.28	3.07
1995.....	2.37	3.21
25-year average.....	2.09	2.82

The adequacy of the financing is assessed according to the "actuarial balance" of income and current cost rates. The actuarial balance is the difference between the average of the tax rates specified in the bill and the average over 25 years of the current cost rates. The actuarial balances of the committee bill and those of present law are shown in table 10 below.

TABLE 10.—ACTUARIAL BALANCE FOR HOSPITAL INSURANCE
UNDER PRESENT LAW AND COMMITTEE BILL

[In percent]

	Present law	Committee bill
Average tax rate.....	2.10	2.83
Average current cost.....	2.09	2.82
Actuarial balance.....	.01	.01

The adequacy of the financing also depends upon whether the assumptions used in estimating both income and outgo turn out to be sound forecasts of the future. The assumptions underlying the estimates in this report are the same as those used in the 1972 Report of the Board of Trustees of the Hospital Insurance Program, and a full discussion is available in the actuarial appendix to that report. Estimates for the hospital insurance program depend particularly on the increase in the cost of hospital services. The increases underlying these cost estimates assume that significant pressure will be exerted to restrain the increases in the cost of hospital services, either through price controls, or other substantial public regulation. Such pressure is already being applied through the reimbursement procedures adopted to enforce the wage-price guidelines. The long-run assumptions as to hospital cost increases assume that such pressure to contain costs will be intensified. If not, the long-run cost of the hospital insurance program may be substantially greater than shown in these estimates. At the same time, however, effective functioning of professional standards review organizations might well reduce the utilization of services and thereby lower program cost estimates.

SHORT-RANGE ESTIMATES OF CASH INCOME AND OUTGO

Estimates of the cash income and outgo of the hospital insurance trust fund and the resulting balance in the trust fund in 1972-77 are summarized in table 11 below for the committee bill, and compared to estimates for present law.

TABLE 11.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER PRESENT LAW AND UNDER COMMITTEE BILL

	1972	1973	1974	1975	1976	1977
Present law:						
Income:						
Contributions.....	5,576	9,349	10,635	11,493	12,114	13,127
General revenue contribution for the uninsured.....	504	468	566	572	577	573
Military wage credits.....	48	48	48	48	48	48
Transfer from railroad retirement.....	65	89	112	119	122	122
Interest.....	164	226	388	563	721	860
Total income.....	6,357	10,180	11,749	12,795	13,582	14,730
Disbursements:						
Benefits.....	6,614	7,464	8,486	9,611	10,830	12,119
Administrative costs.....	165	187	212	240	271	303
Total disbursements.....	6,779	7,651	8,698	9,851	11,101	12,422
Fund at end of year.....	2,612	5,141	8,192	11,136	13,617	15,925
Wage base.....	9,000	10,800	12,000	12,600	12,600	14,100
Tax rate.....	1.2	1.8	1.8	1.8	1.8	1.8

Committee bill:

Income:						
Contributions.....	5,576	11,653	12,998	14,047	14,806	16,044
General revenue contribution for the uninsured.....	504	468	566	572	577	573
Military wage credits.....	48	48	48	48	48	48
Transfer from railroad retirement.....	65	103	137	145	149	149
Interest.....	164	262	462	626	753	842
Total income.....	6,357	12,534	14,211	15,438	16,333	17,656
Disbursements:						
Benefits.....	6,614	8,502	10,813	12,525	14,155	15,897
Administrative costs.....	165	257	311	356	401	448
Total disbursements.....	6,779	8,759	11,124	12,881	14,556	16,345
Fund at end of year.....	2,612	6,387	9,474	12,031	13,808	15,119
Wage base.....	9,000	10,800	12,000	12,600	12,600	14,100
Tax rate.....	1.2	2.2	2.2	2.2	2.2	2.2

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SUMMARY AND CONCLUSIONS

The committee has provided, following the actuarial assumptions and recommendations of the Social Security Administration, for adequate financing of the hospital insurance program over 25 years into the future through tax rates specified in the bill. These tax rates are adequate to support current benefits and administrative expenses and to build the trust fund to the level of a year's expenditure and maintain the trust fund at that level. The actuarial methodology used in deriving the tax rates that would be required to meet these objectives, although slightly different from that used in the past by the committee, is the same as that underlying the cost estimates presented in the 1972 Report of the Board of Trustees of the Hospital Insurance Program.

APPENDIX A.—EXCERPT FROM 1972 TRUSTEES' REPORT ON HOSPITAL
INSURANCE

(NOTE.—In this excerpt from the 1972 Trustees' Report on the Hospital Insurance Trust Fund, costs expressed as a percentage of payroll do not take into account the subsequent enactment of Public Law 92-336, which provides for a \$12,000 limit on wages taxable in 1974.)

ASSUMPTIONS AND METHODOLOGY FOR LONG-RANGE COST ESTIMATES

The basic methodology and assumptions for the long-range cost estimates for the hospital insurance program are described in this appendix.

1. *Methodology*

The adequacy of financing for the hospital insurance program for the next 25 years is expressed in this report as an actuarial balance. The actuarial balance is calculated as the difference between the average tax rates specified in current law and the average current cost rate for the 25 year period. The current cost rate for any year is the incurred cost of benefits and administration for insured persons divided by the incurred effective payroll for that year, plus an amount (expressed as a percent of payroll) required to build the trust fund balance to the level of a full year's benefits by 1985 and maintain it at that level thereafter. In projecting the incurred payroll, it is assumed that the wage base is adjusted periodically to keep pace with rising earnings.

The actuarial balance is —0.61% of payroll indicating that the program is seriously underfinanced.

2. *Principal problems in forecasting the cost of the hospital insurance program*

The principal problems involved in forecasting the future costs of the hospital insurance program are (1) establishment of the current cost of the services provided by type of service, to serve as a base for projecting the future, and (2) forecasting of the increase in the cost of hospital services (which account for approximately 95% of the cost of the program).

(a) *Problems involved in establishing the current cost of services incurred as a base for forecasting future costs.*—In order to establish a suitable base from which to forecast the future costs of the hospital insurance program, it is necessary to eliminate the effect of any transitory factors. Thus the initial problem is to find the incurred cost of services provided for the most recent year for which reliable estimates can be made. To do this, the non-recurring effects of any changes in regulations or administration of the program and of any irregularities in the system of payments to providers must be eliminated.

The reimbursement system of the hospital insurance program is intended to reimburse institutions for the actual cost of providing covered services concurrently with the provision of the services. Payment is initially made on an "interim" or temporary basis. In theory, the rate at which such interim payments are made is an estimate of the actual average cost of providing the services. Actually, on the average, these rates are set lower than the estimated costs, as recovery of any overpayment is thought to pose a serious problem for the institutions' management. Due to the time required for (1) the institutions to bill intermediaries, (2) for the intermediaries to query the Social Security Administration to determine the spell of illness status of the patient, determine that the services are covered, and draw checks for approved services; and (3) for the institutions to present these checks for payment—there is a lag between the date on which services are performed and on which payment therefor on an interim basis is received.

In order to bring interim reimbursements up to a current basis, an amount, not exceeding the program liability for services performed but for which no payment has been made, can be advanced to the institution. Such amounts are referred to as "current financing" payments.

Another method of interim reimbursement, called the "periodic interim payment" method, achieves the same results as current financing by making regular payments to the hospitals at short intervals throughout the year. The payments are based on cost studies of past experience and are not delayed until individual bills are submitted.

In order to adjust interim payments to the actual cost of providing services (as determined by an audited cost report which makes the necessary allocations of all of an institution's costs on a functional basis), a series of settlements are made with each institution. These payments have run 4% to 5% of interim payments during the early years of the program. Due to the time that has been required to obtain cost reports from institutions and to verify and audit these reports, the settlements have lagged behind the liability for such payments, as much as several years for many institutions. The final cost of the program has not been completely determined even for the initial year of the program, and more uncertainty exists as to the final cost of subsequent years. An additional complication stems from the policy of reimbursing the hospital insurance program from the SMI program for the cost of certain salaried physicians. If a hospital has an agreement with salaried radiologists and pathologists under which the institution bills for the professional component of these services, interim payments are made from the hospital insurance trust fund and later reimbursed from the supplementary medical insurance trust fund on the basis of that hospital's cost report. There is no reliable statistical information concerning these costs, which must be estimated from the settlements. Interim transfers are also made from the supplementary medical insurance trust fund to the hospital trust fund for the estimated difference between current incurred costs and cash settlements for these services. Since the beginning of the hospital insurance program, the incidence of payments other than those for interim costs

have been irregular, and consequently have distorted the cash expenditure figures. For example, in the early years of the program, relatively few cost settlements were made. In later years, there was some catching up, through making more than one settlement payment to some hospitals in the same year. These changes in the incidence of payment undermine judgments as to the ongoing cost of the program from the present cost. Further, inadequate aggregate data concerning the periods for which the various payments other than interim costs have been made, and the incomplete filing of audited cost reports—have prevented accurate reconstitution of the actual costs.

Additional problems are posed by changes in administrative or reimbursement policy which have a substantial effect on either the amount or incidence of payment. For example, the 2% allowance for unallocated costs that was paid during the initial years of the program was discontinued in July 1969. The extent and incidence with which this change was incorporated into interim payment rates is not known.

Further, regulations were promulgated in July 1971 which specify that a similar allowance will be made for the higher than average cost of performing certain services (e.g. nursing) for aged patients. Reimbursement will be made retroactively for these "differential" costs, which will add approximately \$100 million of non-recurring expenditures which should be paid during fiscal 1972, but may be paid partially in subsequent years. The new allowance for differential costs will also increase the liability of the program in all future years. Allocating the various payments to the proper periods, using incomplete data and estimating the impact of administrative actions present very difficult problems—the solution of which can only be approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This situation has the dual effect of (1) increasing the error of forecast directly, through incorporating any error in estimating the base year into all future years, and (2) lengthening the periods that must be forecast, since a projection of the most recent year is more accurate than an attempt to reconstruct the actual cost in that year.

Hospital insurance program data from 1968 indicate that aged patients used 4.13 days per capita of hospital services and 1.08 days per capita of extended care facility services.

Program data for 1970, corrected for anticipated final settlements with providers, indicates that the average cost of a day of hospital care for the aged was \$62.17 per day for insured persons and \$55.28 per day for the uninsured. The insured paid 6.3% of their costs themselves in the form of the inpatient deductible and coinsurance. In 1970, the average cost per day in extended care facilities for services covered by the hospital insurance program was \$22.19 for insured persons and \$20.56 for uninsured persons. The unit cost of home health services was approximately \$12.30 in 1970.

(b) *Problem involved in forecasting the increase in hospital costs.*—In order to evaluate the adequacy of a tax schedule to support the hospital insurance program, it is necessary to relate the increases in the costs of institutional care to the increases in covered earnings which support those costs. Hospital insurance cost increases due to increases in covered population are fairly stable and predictable. The cost of the services provided per capita, however, have varied substantially from year to year. The next section discusses in detail the problems involved in forecasting hospital costs.

3. *Principal assumptions used in forecasting future costs of the hospital insurance program*

(a) *Trend in hospital costs and the impact of the Economic Stabilization Program.*—The increase in the cost per capita of hospital services may be analyzed into the following components:

(1) The number of days of confinement in a hospital per capita: the level of use of inpatient care by the covered population.

(2) Factor prices: the increase in unit costs that would result if every function was performed in precisely the same way by the same people and only the salaries of the people employed or the cost of the equipment and other supplies used changed.

(3) Increases due to changes in the services provided per patient day and the method of provision consisting of—

(a) Change in the method of providing services, i.e., any increase (or decrease) in unit costs for providing the same services, other than those due to factor price increases. This component consists of two different types of influences:

(i) Improvements to a given service, normally increasing the unit cost.

(ii) The effect of more efficient techniques or use of labor saving equipment, which normally decrease the unit cost.

(b) Provision of new services not previously provided (normally new, technically advanced services).

(c) Number and composition by relative expense of services furnished per day of care.

It has been possible to isolate some of these elements and identify their role in previous hospital cost increases. The increases due to changes in services provided (per patient day) and the method of provision, however, must be combined to use available data, and separated into (i) a portion due to hiring more employees per day of care provided and (ii) a residual due to all other causes. A large portion of historical increases must thus be studied only as a residual element. Table A shows the historical values of the principal components of the increase together with the forecasts underlying the increases in hospital costs per capita used in the estimates.

Hospital use, as measured by the number of inpatient days per capita, depends on many factors such as medical practice, administrative policies of health insurers, and chance fluctuations in morbidity.

TABLE A.—COMPONENTS OF INCREASE IN COST OF HOSPITAL SERVICES PER CAPITA FOR THE AGED (INCREASE IN YEAR SHOWN OVER PREVIOUS YEAR)

[In percent]

Year	Patient days per capita ¹	Factor prices ²	Due to change in services and how provided ³	Total increase ¹
	(1)	(2)	(3)	(4)
I. Historical data:				
1956-65.....		3.5	3.2	.....
1966.....		1.5	6.7	.....
1967.....	2.4	6.7	7.6	17.6
1968.....	7.3	7.6	7.2	23.4
1969.....	1.5	7.8	5.5	15.4
1970.....	-2.0	8.4	4.5	10.9
II. Forecast:				
1971.....	-1.5	7.1	4.6	10.3
1972.....	1.0	5.7	4.5	11.6
1973.....	.5	5.7	4.4	11.1
1974.....	.5	5.7	4.3	11.1
1975.....	.5	5.6	4.2	10.6
1980.....	0	4.6	2.8	7.5
1983 and later.....	0	4.1	1.8	6.0

¹ Historical data from health insurance program.

² See table B.

³ See table C.

TABLE B.—PRICE INCREASES FOR FACTORS USED BY HOSPITALS (INCREASE IN YEAR SHOWN OVER PREVIOUS YEAR)

[In percent]

Year	Average earnings in covered employment ¹	Average wages of hospital employees ²	CPI all items	Average factor prices
I. Historical data:				
1956-65.....	3.6	4.7	1.6	3.5
1966.....	4.4	0.6	2.9	1.5
1967.....	6.3	9.3	2.9	6.7
1968.....	7.0	9.9	4.2	7.6
1969.....	6.0	9.4	5.4	7.8
1970.....	4.8	10.1	5.9	8.4
II. Forecast:				
1971.....	5.7	9.0	4.3	7.1
1972.....	5.5	7.5	3.0	5.7
1973.....	5.5	7.5	3.0	5.7
1974.....	5.5	7.5	3.0	5.7
1975.....	5.4	7.4	3.0	5.6
1980.....	5.0	5.8	2.9	4.6
1983 and later.....	5.0	5.0	2.8	4.1

¹ Average earnings subject to OASDI taxes in first quarter.² Historical data from American Hospital Association.

The past three decades have witnessed a long term increasing trend in the number of days of hospital care per capita. In 1970 and 1971, however, use of hospital facilities decreased for the aged population, due to a shorter average length of stay. By contrast, the admission rate per capita continued to grow. In view of this two year downturn in utilization, the estimates of future increases in utilization have been substantially decreased from those shown in last year's report, assuming an increase of only ½% per year through 1977 and no increase thereafter. An additional increase of ½% is assumed in 1972 to provide an allowance for the expected value of additional hospital stays due to influenza epidemics, none of which occurred in the base year. Table A shows the actual experience under the health insurance pro-

gram for 1967-1968 and the assumptions used to project hospital costs for subsequent years.

Hospital factor prices can be divided into those for personnel and those for non-personnel expenditures. Approximately 60% of hospital costs are for personnel. For several years preceding the beginning of the hospital insurance program, average hospital wages and salaries (as reported by the American Hospital Association) increased at a rate of about 1% per year more than the rate of increase in earnings in OASDI covered employment. Since the beginning of the hospital insurance program, this differential has been about 3% per year.

The Pay Board has restricted wage increases to the range 5% to 6% per year, but has exempted very low paid workers from this standard and has approved many settlements at a higher rate. More important, the Price Board has ruled that the costs established by the Social Security Administration for reimbursement purposes are prices and that such reimbursements cannot recognize any increase in wages and salaries higher than 5½% per year (although with unlimited provision for exceptions through rulings). Part of the increase in average wages has been due to a change in composition of the work force so as to include relatively more higher paid personnel; this part of the increase is not restricted by the wage guidelines. The cost estimates assume that the immediate impact of these controls will be to reduce the average increase in hospital wages to 7½% per year during 1972-74, still higher than the 5½% assumed for all workers. Eventually, this difference should disappear entirely as hospital workers' wages become comparable to those for similar workers in other industries and the proportion of highly trained personnel grows very large; this has been assumed to occur by 1983.

Increases in the prices of the goods and services hospitals purchase are treated as a function of increases in the Consumer Price Index for all items. There is some question as to whether this index is appropriate since hospitals purchase a large volume of services. No index of hospital non-personnel factor prices is available, however. The price increases that may be recognized for reimbursement under the Price Commission guidelines are limited to 2½% per year. Part of the increase is due to the mix of goods and services purchased, which is not subject to this limit. Table B summarizes the historical data used and the comparable forecasts in estimating the increase in factor prices.

Since the beginning of the hospital insurance program, the number of hospital workers per adjusted 100 census count in nonfederal short-term general hospitals has been increasing about 3% per year (as reported by the American Hospital Association). Statistics adjusted for changes in outpatient care are not available prior to 1966, but some indicators suggest a level of about 2% per year.

TABLE C.—INCREASES IN HOSPITAL COSTS PER PATIENT DAY
DUE TO CHANGES IN SERVICES AND METHOD OF PROVISION¹
(INCREASE IN YEAR SHOWN OVER PREVIOUS YEAR)

[In percent]

Year	Employees per patient day ²	Nonemployee increases ³	Increases due to changes in serv- ices and method of provision
I. Historical data:			
1956-65	2.0	5.0	3.2
1966	5.8	8.2	6.7
1967	1.7	16.5	7.6
1968	2.5	14.0	7.1
1969	4.0	8.0	5.6
1970	3.1	6.6	4.5
II. Forecast:			
1971	3.0	7.0	4.6
1972	2.9	6.9	4.5
1973	2.8	6.8	4.4
1974	2.7	6.7	4.3
1975	2.6	5.6	4.2
1980	2.0	4.0	2.8
1983 and later.....	1.0	3.0	1.8

¹ See text for explanation.

² Historical data are from American Hospital Association. These increases apply only to that part of hospital expenses due to personnel, which are approximately 60 percent of hospital costs.

³ Actually a residual; i.e. the increase in hospital costs not explained by increases in days of inpatient care per capita, factor cost increases, or the number of employees per patient day. Expressed so as to apply to nonpersonnel costs.

A residual item is required to balance the historical increases in hospital costs, which allows for the effect of changes in the services provided and method of provision not accounted for by an increase in the number of personnel (this item is stated so as to apply only to nonpersonnel costs). Before 1966, this residual averaged about 5% per year. After a surge in the early years of the hospital insurance program, 16½% in 1967 and 14% in 1968, the residual has declined to a level of around 7% in 1969-1970.

Hospital cost increases due to changes in the services provided and method of provision will be partially restricted under the Price Commission guidelines, which specify that "aggregate expenses for new technology such as new equipment and new services directly related to health care, to the extent they are not charged directly to persons benefiting directly from that equipment or those services, which exceed 1.7% of total annual expenses" cannot be recognized for reimbursement purposes. This limitation thus applies jointly to items (3) (a) and (3) (b), but not to (3) (c)—assuming hospital managements will charge users for any new services offered, including services that in the absence of controls would have been included in the room and

board charge. To use the data base available, a judgment is thus required as to the portion of the total increase due to changes in the services provided and method of provision that is due to new services; the rest of this component is restricted to 1.7% per year. There are, however, many items whose attribution in cost accounting is not clearly designated. With constraints on other costs, there is pressure on hospital managements to adopt policies which allocate more of the cost of overhead items to new services than might otherwise have been the case. The historical data related to increases in cost due to changes in the services, analyzed by personnel and non-personnel subcomponents, are shown in table C, together with the forecast for the future.

It is assumed that the current rate of increase in the number of personnel per adjusted census of around 3% per year will continue for a few years and then gradually decrease to a level of about 1% per year, a level lower than obtained before the hospital insurance program. The 1% per year is assumed to persist over the full period for which estimates are prepared.

The restriction on increases due to changes in the services and method of provision is estimated to reduce moderately the non-labor portion of this component of the increase in the immediate future. It is assumed that ultimately this rate will drop to 3% per year, a level substantially lower than that which prevailed during the decade before the hospital insurance program began.

Table A shows the increases in hospital costs that have occurred under the hospital insurance program, and those resulting from compounding the forecasts for each of the three principal components into which such increases were analyzed. It can be noted that the long run increases are assumed to be higher than the long run increases in earnings, and hence in income, so that the current cost of the program rises indefinitely. Such increases assume a willingness on the part of the public to spend part of the increases in real income resulting from the differences between earnings and consumer prices on higher quality hospital care, at a rate of 1% per year. As emphasized throughout this report, this rate is below the historical average and far below the rate experienced since the beginning of the hospital insurance program. It thus presumes a significant amount of public pressure to reduce the increases in hospital costs as the cost of these services bite deeper into disposable income, either directly through payment of higher charges or indirectly in the form of higher insurance premiums and taxes to support government programs. It is also assumed that the investments of Federal programs in quality of hospital management should in the longer run reduce the cost of care.

(b) *Assumptions as to increases in the cost per capita of extended care facility benefits.*—Utilization of extended care facilities dropped very sharply in 1970 and moderately in the first quarter of 1971 as a result of strict enforcement of regulations separating convalescent from custodial care. Adjusted for the trend to increasing use of these facilities, the current level of utilization is a little over half of that which occurred during the early years of the program. It is anticipated that increases in utilization are to be anticipated over the next several years, however, as providers and patients become more familiar with

the level of care covered in these institutions under the new administrative policies.

Increases in the average cost per day in extended care facilities under the program are caused principally by (i) the higher cost of the nurses and other skilled labor required and (ii) the addition to covered facilities of new, better equipped, and more expensive facilities. Nurses have been in particularly short supply since the beginning of the hospital insurance program, and consequently their wages have been increasing far more rapidly than earnings in general. This trend may be expected to continue for the foreseeable future due to (i) the continued rapid increase in demand for nursing services and (ii) the opening of a wide variety of occupations to women, forcing employers of nurses to be more competitive in wages and working conditions.

The average cost per day of extended care facility services covered by the program increased by approximately 10% in 1970 over 1969. It is assumed that a similar level of cost increases will prevail for a few years and then gradually decrease so as to merge with the annual rate of increase in general wages by 1982. The resulting increases in the cost per capita of extended care facility services are shown in table D.

TABLE D.—PERCENT INCREASES IN COST PER CAPITA BY TYPE OF SERVICE ASSUMED FOR FORECASTING THE CURRENT COST RATES OF THE HOSPITAL INSURANCE PROGRAM IN THE 1972 TRUSTEES REPORT (INCREASE OVER PRIOR YEAR)

[In percent]

Year	Hospitals	Extended care facilities	Home health agencies
1970.....	11.4	-26	19.5
1971.....	10.5	0	19.5
1972.....	11.5	15	19.5
1973.....	11.0	22	19.0
1974.....	11.0	21	18.0
1975.....	10.5	19	18.0
1976.....	10.5	16	15.0
1977.....	9.5	12	11.0
1978.....	8.5	11	10.0
1979.....	8.0	9	8.0
1980.....	7.5	7	7.0
1981.....	7.0	6	6.0
1982.....	6.5	5	5.0
1983 and later.....	6.0	5	5.0

The long run assumption that increases in the cost per day of care in extended care facilities will be equal to the increases in the average earnings after 1981 requires increases in productivity to offset the higher than average increases in earnings anticipated for nurses and any tendency to upgrade the quality of services. As in the case of hospitals, public pressure to contain these costs will be required, through legislation if necessary.

(c) *Assumptions as to home health service benefits.*—Data on utilization of home health services are very slow in reaching the Social Security Administration. Early in the program, increases in utilization were very large, running around 30% per year; but it now appears that the rate of increase may be substantially lower, perhaps 10% per year. The assumptions used in the cost estimates are shown in table D.

(d) *Administrative expenses.*—Total administrative expenses are assumed to be 2½% of benefits through 1977. After that, the projection assumes that the per capita expenses increase at 4% each year—that is, 1% less than the projected increase in all wages in covered employment.

(e) *Interest rate.*—It has been assumed that trust fund investments will earn an average of 6% interest per annum. The actual rate earned on the hospital insurance trust fund during fiscal 1971 was 6.5%.

(f) *Population.*—The population projections used in this report are based on those in *Actuarial Study Number 62*, Social Security Administration.

4. *Sensitivity testing of long term cost estimates*

Sensitivity testing has always been incorporated in examination of the cost of the hospital insurance program; but the results of these sensitivity studies have not been shown explicitly in the reports. Sensitivity testing reported here is limited to investigating the effect of a single change in the assumptions as to the long term increases in hospital costs, to reflect a weaker degree of public pressure to contain such costs. For this test the rate of hospital cost increases for 1981 and later is held at the 1980 level (7.5%), rather than declining to 6% for 1983 and later as assumed in the cost estimates. The higher level after 1980 assumes the same excess of hospital cost increases over factor cost increases that prevailed in the decade before the beginning of the hospital insurance program.

A summary of the assumptions used in this test appears in table E and the resulting current cost ratios appear in table F.

5. *Accuracy of past estimates*

Table G compares the actual incurred expenditures for the hospital insurance program with the estimates of such expenditures prepared at various times in the past. Since the estimates of incurred expenditures are used primarily to recommend and test the financing of the program, the appropriate test of these estimates is to compare the estimated current cost rates to the actual results.

The earliest of these estimates, prepared before any program experience was available, underestimated the first year and one half of expenditures by around 8%, but because of too little allowance for what proved to be a steep trend, underestimated 1971 expenditure by 27%.

The 1967 estimate was about 10% low for 1968, and 18% low for 1971, again indicating that the increase in hospital costs over the period was sharper than anticipated.

TABLE E.—INCREASES IN COST PER CAPITA BY TYPE OF SERVICE ASSUMED FOR FORECASTING THE CURRENT COST RATES FOR THE HOSPITAL INSURANCE PROGRAM IF THE LONG-RANGE INCREASE IN HOSPITAL COSTS IS COMPARABLE TO THAT IN THE DECADE BEFORE 1966 (INCREASE OVER PRIOR YEAR)

[In percent]

Calendar year	Hospitals	Extended care facilities	Home health agencies
1970.....	11.4	-26	19.5
1971.....	10.5	0	19.5
1972.....	11.5	15	19.5
1973.....	11.0	22	19.0
1974.....	11.0	21	18.0
1975.....	10.5	19	18.0
1976.....	10.0	16	15.0
1977.....	9.5	12	11.0
1978.....	8.5	11	10.0
1979.....	8.0	9	8.0
1980.....	7.5	7	7.0
1981.....	7.5	6	6.0
1982.....	7.5	5	5.0
1983 and later.....	7.5	5	5.0

TABLE F.—INCURRED COST¹ OF HOSPITAL INSURANCE PROGRAM (FOR THE INSURED ONLY) AS A PERCENT OF TAXABLE PAYROLL²

[In percent]

Calendar year	Incurred cost
1972.....	1.50
1973.....	1.60
1974.....	1.70
1975.....	1.80
1980.....	2.20
1985.....	2.40
1990.....	2.76
1995.....	3.08
25 year average.....	2.38

¹ Benefit payments and administrative expense, plus a provision for trust fund growth equal to one year's expenditures for 1985 and thereafter.

² Earnings in covered employment and taxable earnings base assumed to rise 5% annually.

TABLE G.—COMPARISON OF PREVIOUS COST ESTIMATES
EXPRESSED AS A PERCENT OF TAXABLE PAYROLL WITH
ACTUAL RESULTS ¹

[In percent]

	Date estimate made			Actual ⁵
	July 1965 ²	Decem- ber 1967 ³	March 1970 ⁴	
Estimate of experience in:				
1966.....	0.41			0.39
1967.....	.82			.95
1968.....	.82	0.93		1.03
1969.....	.87	.98		1.09
1970.....	.91	1.03	1.19	1.17
1971.....	.95	1.07	1.32	1.30

¹ The estimated benefits and administrative expenses shown are divided by the effective payroll; i.e., that payroll which when multiplied by the combined tax rate for employers and employees together, will produce the estimated contribution income.

² Committee on Ways and Means, Committee Print 51-291, July 30, 1965. The contributions for 1966 and 1967 were adjusted to an incurred basis using the assumption made in 1965 that the average lag between incurred and cash contributions is 1 month.

³ Committee on Ways and Means, Committee Print 87-369, Dec. 11, 1967.

⁴ 1970 Trustees' Report for the HI program.

⁵ See table H.

The 1970 estimate proved to be very accurate for each of its first two years, this time overestimating the expenditure by a small margin. Much more information was available for this estimate than for those made earlier.

The estimates shown are not strictly comparable, due to the changes in legislation or regulations between the date on which an estimate was prepared and the year for which it was made. For example, for the initial estimates prepared for the House Ways and Means Committee in February 1965 (and reported in the Committee Report published on July 30, 1965) the following adjustments should be made for comparability:

(1) Increase in benefits as a result of the 1967 Amendments, raising the cost of the program by approximately 1/2% per year after 1967.

(2) Change in the earnings base applicable to 1968 and subsequent years from \$6,600 to \$7,800, which increased the covered payroll by approximately 7% in 1968, by 6% in 1971, and by lower amounts in later years.

(3) Passage of legislation including hospital workers under the minimum wage.

(4) Payment to hospitals of an allowance of 2% of costs in addition to all determinable costs. For reimbursements for services provided after June 1969, this allowance was reduced to approximately 1.2% of costs.

(5) Payment during the initial years of the program for services in a very large number of extended care facilities which did not meet the standards set forth under the law but that were taking steps to overcome the deficiencies that prevented meeting such standards. (Most of these institutions were subsequently dropped.)

(6) Payment during the initial years of the program for a larger proportion of the services in extended care facilities than specified in the law. (This situation was subsequently corrected, resulting in a decrease in extended care patient days per capita of approximately 50%.)

There are also many less important differences between specifications at the time of enactment and the actual program that developed. Rates comparable to the 1965 estimates that have been standardized for the above factors (except the minimum wage legislation) would be as follows:

TABLE H.—COMPARISON OF ESTIMATED AND ACTUAL HOSPITAL INSURANCE TAX RATES

[In percent]

Year	Estimate	Standardized	Actual	Ratio to actual
1966.....	0.41	0.42	0.39	1.08
1967.....	.82	.87	.95	.92
1968.....	.82	.82	1.03	.80
1969.....	.87	.86	1.09	.79
1970.....	.91	.89	1.17	.76
1971.....	.95	.93	1.30	.72

The standardized rates are only 4% low for the first year and one half of the program, but are 28% low for 1971.

The more past experience available at the time of an estimate, and the shorter the time period between date of estimate and the year being estimated, the more accuracy one should expect. Experience with the hospital insurance program to date bears out this expectation. There is nonetheless much that can go wrong in the estimation process, and present estimates for years far in the future must be considered to have a relatively large likelihood for substantial error.

D. Cost Estimates for the Supplementary Medical Insurance Program

PRINCIPAL IMPACT OF COMMITTEE ACTIONS

The committee bill substantially expands the protection provided by the supplementary medical insurance program, by extending its provisions, effective July 1, 1973, to disabled workers under age 65 (and to disabled widows and widowers, and to beneficiaries entitled to child's 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 consecutive months. Due to the provision in the committee bill to reduce the waiting period for disability insurance benefits from 6 to 4 months, coverage will become effective in the 29th consecutive month of disability. The protection under the SMI system is automatic for these disabled beneficiaries although they may optionally disenroll.

The average cost for the disabled enrollees under age 65 will be much higher than the average cost for the age 65 and older enrollees now under the program. The premium rate charged to disabled enrollees under age 65 will be the same, however, as the rate charged to enrollees age 65 or older. Any difference between an actuarially adequate rate and the premium rate charged will be financed from the general fund of the Treasury. The additional general revenue financing required in calendar year 1974 is \$426 million.

LIMITATION ON THE INCREASE IN SMI PREMIUM RATE

The committee bill provides for the SMI premium rate to be promulgated during December of each year for the 12 month period commencing on July 1st of the succeeding year, as is presently the case. However, the bill provides that the premium rate shall be the lessor of (i) the "actuarially adequate rate" for enrollees 65 and over as determined under current law and (ii) the premium rate promulgated the previous December increased by the rate of increase in cash benefits. Such rate of increase in cash benefits will be equal to the increase in the general level of cash benefits from that which appears in the cash benefit table for June 1st of the year in which the premium is promulgated to that which will appear (or is believed will appear) June 1st of the succeeding year. Thus, the increase that can occur in the premium rate which takes effect in July of any year cannot be greater relatively than the increase in cash benefits that occurred during the previous 12 months. The limitation will affect premium rates promulgated in December of 1972 and subsequent years.

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. The bill provides that the supplementary medical insurance trust fund will be reimbursed from the general fund of the Treasury for the excess of the incurred cost of the program over the premiums collected. The incurred cost of the program, on which such reimbursement from the general fund of the Treasury will be based, is determined by the "actuarially adequate rates" promulgated by the Secretary of Health, Education, and Welfare for aged beneficiaries and disabled insurance beneficiaries respectively. Such rates will be $\frac{1}{2}$ of the average monthly cost of benefits and related administration for services provided under the program during the fiscal year to which the rate applies for aged and for disabled beneficiaries separately. Such actuarially adequate rates will be determined and promulgated in December for the subsequent fiscal year beginning the following July.

The actuarially adequate rates to be promulgated in December 1972 will include the cost of the new benefits provided by the committee bill, which take effect prior to the period, fiscal 1973, to which these rates apply. The actuarially adequate rate for the aged will thus increase over the current premium rate due not only to the normal increase in cost per enrollee of the program (due to price increases and relatively greater use of more expensive services) but also as a result of such new benefits. As a result of the 1972 amendments to the Social Security Act, however, the general level of cash benefits will increase by 20 percent in September 1972. Since the increase in cost due to normal increases and the new benefits combined are less than 20 percent, the limitation on premium increases will have no effect on the premium promulgated for fiscal 1974.

The effect of the limitation on the premium rate for the aged and of the limitation of the premium rate for the disabled to that charged the aged is that a greater proportion of the program will be paid from general revenues than has been the case in the past.

SUMMARY OF OTHER CHANGES WHICH HAVE A SIGNIFICANT IMPACT ON COST

The committee has also adopted several other changes which have a significant impact on the cost of the supplementary medical insurance program. A summary of those changes which have a significant impact on cost, together with an estimate of the increase in the premium that will be required when such premium is not constrained by the limitation on increases in the premium rate discussed above, and an estimate of the cash outgo resulting from the change in 1974 follows:

1. Coverage of chiropractors services. 1974 cost: \$113 million. Premium increase: \$.19 per month.
2. Coverage of outpatient rehabilitation care provided in the SMI program and elimination of the House provision for additional coverage of physical therapy in the practitioner's office or patient's home. 1974 cost: \$16 million. Premium increase: \$.03 per month.

3. Coverage of the services of clinical psychologists when furnished through facilities which provide only clinical psychologists' services, as well as clinics, rehabilitation agencies, public health agencies, and providers under the program. (Such services are now covered if the clinic or agency is directed by a physician.) 1974 cost: \$7 million. Premium increase: \$0.01 per month.

4. Coverage of speech pathology when furnished through facilities which provide only speech pathology services, as well as clinics, rehabilitation agencies, public health agencies, and providers under the program. 1974 cost: \$24 million. Premium increase: \$0.04 per month.

The impact of the committee decisions is to increase the expenditures of the SMI program by \$625 million in 1974 and by substantially more in later years when the impact of the liberalization of the disability insurance program will affect the cost of the SMI program. The premium rate will itself be increased by \$.27 per month initially, as a result of those changes which affect the coverage provided to the aged enrollees. Due to the limitation on increases in the premium rate, however, subsequent increases resulting from these provisions may be met from general revenues rather than premium payments from the individuals covered.

The committee has eliminated the provision in the House bill to increase the deductible from \$50 to \$60 per year, which would have reduced the cost of the program by \$115 million in 1974.

SUMMARY OF INCOME AND DISBURSEMENTS

The income and disbursements of the supplemental medical insurance program are summarized in the table below. The disbursements shown are the cash expenditures that will be made in the years indicated and are consistent with the estimates carried in the 1972 President's budget and those in the 1972 Report of the Board of Trustees of the Supplemental Medical Insurance Program. The premium rate during fiscal 1973 is \$5.80, which determines the premiums and general revenue financing during this period. For periods after July 1, 1974, the sum of the income from premiums and general revenue contributions is equal to the incurred cost of benefits and administrative costs. The lag between the time services are performed and the date payment is made for them results in additions to the trust fund, supplemented further by interest earned on the trust fund.

TABLE 12.—ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND UNDER
PRESENT LAW AND COMMITTEE BILL

	1972	1973	1974	1975	1976	1977
Present law:						
Income:						
Premiums.....	1,392	1,508	1,674	1,862	2,067	2,292
General revenue.....	1,406	1,511	1,674	1,862	2,067	2,292
Interest.....	31	39	47	57	67	79
Total income.....	2,829	3,058	3,395	3,781	4,201	4,663
Disbursements:						
Benefits.....	2,340	2,572	2,850	3,169	3,519	3,903
Administrative costs.....	330	355	397	442	491	545
Total disbursements.....	2,670	2,927	3,247	3,611	4,010	4,448
Trust fund at end of year.....	609	740	888	1,058	1,249	1,464

Committee bill:

Income:

Premiums.....	1,392	1,589	1,796	1,889	1,985	2,084
General revenue.....	1,406	1,768	2,239	2,722	3,144	3,607
Interest.....	31	45	61	74	88	103

Total income.....	2,829	3,402	4,096	4,685	5,217	5,794
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Disbursements:

Benefits.....	2,340	2,705	3,407	3,927	4,368	4,851
Administrative costs.....	330	373	465	535	596	663

Total disbursements.....	2,670	3,078	3,872	4,462	4,964	5,514
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Trust fund at end of year.....	609	933	1,157	1,380	1,633	1,913
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**VI. SUPPLEMENTAL SECURITY INCOME FOR THE AGED,
BLIND, AND DISABLED**

(379)

Supplemental Security Income for the Aged, Blind, and Disabled

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VI. SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

(Title III of the bill)

Three categories of needy adults are eligible for federally matched assistance payments: persons 65 and over, blind persons (without regard to age), and permanently and totally disabled persons 18 years of age and older. The programs of aid to the aged, blind, and disabled are State-administered, with States setting the payment levels. The committee bill would replace these welfare programs with a new Federal Supplemental Security Income program.

Under the new program, aged, blind, and disabled people would be assured a monthly income of at least \$130 for one person living alone and \$195 for a couple.

In addition, the first \$50 of social security or other income and an additional \$85 of earned income would not cause any reduction in the amount of the supplementary income payment.

Present Law

Under present law for the Federally matched welfare programs, each State establishes a minimum standard of living (needs standard) upon which assistance payments are based; any aged, blind or disabled person whose income is below the State needs standard will be eligible for some assistance, although the State need not pay the full difference between the individual's income and the needs standard.

Generally speaking, all income and resources of an aged, blind or disabled person must be considered in determining the amount of the assistance payment (though a portion of earnings may be disregarded as a work incentive). States also place limitations on the real and personal property an aged, blind or disabled individual may retain without being disqualified for assistance.

Monthly State payments to an aged, blind or disabled individual with no other income range between \$66 and \$250 and for an aged couple between \$121 and \$350.

The current State assistance levels are shown in tables 1 and 2.

House Bill

The House-passed bill would establish a new Federal assistance program for the needy aged, blind and disabled which would:

(1) replace 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) provide that each needy 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

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

In August 1971 the President requested that the effective date for the welfare provisions of the House-passed bill be delayed for one year. Thus, the \$150 Federal guaranteed minimum income for the aged, blind and disabled would become effective in July 1975 rather than July 1974.

Committee Bill

The committee bill would make a major departure from the traditional concept of public assistance as it now applies to the aged, the blind, and the disabled. Building on the present social security program, it would create a new Federal program administered by the Social Security Administration, designed to provide a positive assurance that the Nation's aged, blind, and disabled people would no longer have to subsist on below-poverty-level incomes.

Eligibility

Under the new Supplemental Security Income program, persons 65 and over, blind persons, and disabled persons would be assured an income of \$130 a month for individuals and \$195 a month for couples. Individuals (or couples) with assets (other than excluded assets) of more than \$2,500 would not qualify for Supplemental Security Income payments.

The committee 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 the new supplemental income program.

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.

The Secretary would be expected to secure the needed medical evidence where the evidence was needed to make a sound determination.

An individual 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 December 1973 under existing State programs would be considered blind or disabled for purposes of this program provided that they meet the definition of disability or blindness which was in effect as of October 1972.

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.

The House-passed bill would extend Federal benefits to permanently and totally disabled children under age 18. The benefits would be substantially higher than benefits for these children if they received family welfare benefits. Parents' income and resources would have to be taken into account in determining the eligibility and benefits of children under 21, and the benefit would be reduced by one-third to reflect the value of room and board provided by the parent to the child.

The House justified its inclusion of disabled children under age 18 under aid to the disabled, if it is to their advantage, rather than under the program for families with children, on the grounds that their needs are often greater than those of nondisabled children. The needs of disabled children, however, are generally greater only in the area of health care expenses. In all but the two States that do not have medicaid programs, children now eligible for cash assistance are covered under existing State medical assistance programs. Disabled children's needs for food, clothing, and shelter are usually no greater than the needs of nondisabled children.

Under the committee bill, the new income security program would apply only to disabled persons 18 years of age and older.

Benefits under the new program would be paid only to people who are residents of the 50 States and the District of Columbia, and who are either United States citizens or aliens lawfully admitted for permanent residence. (The present provisions of Titles I, X, XIV, and XVI of the Social Security Act would continue in effect for Puerto Rico, the Virgin Islands, and Guam.) 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.

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 condi-

tions 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 the extremely disabled—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.

In keeping with the basic concept of the new program as providing supplemental security income, beneficiaries and prospective beneficiaries would be required to apply for, and make every effort to obtain, all other benefits for which they might be eligible. 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 or other conditions with respect to the other benefit could not be met, or applying for the other benefit would otherwise be futile, the provision would not operate.

In determining marital status, State law will apply, except that, if a couple has been determined married for purposes of 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 new 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 that an eligible individual and spouse will receive a couple's benefit until they have lived apart for six months.

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 supplemental security benefits will be paid to an individual in a penal institution.

Determination of Income and Resources

Definitions of income.—Income for purposes of the 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 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 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 programs.

The House-passed bill sets a guaranteed minimum income level for aged, blind, and disabled persons which will eventually reach \$150 per month. The House bill allows a portion of earned income to be disregarded, but reduces assistance payments one dollar for each dollar of social security benefits or other unearned income. Thus under the House bill, an individual who retires after working for many years under social security could end up with exactly the same total monthly income as an individual who had never worked, or his social security benefits might be little more than the assistance payment he would receive if he had never worked. The committee is concerned that the value to him of his years of working and contributing to social security is little or nothing.

The committee also recognizes that some people do not qualify for social security benefits because their work was not covered, but have attempted to provide themselves with a regular source of income from some other source—a small annuity or public pension, perhaps.

In the opinion of the committee, these provisions in present law and in the House-passed version of H.R. 1 give inadequate recognition to the efforts working people make to provide for themselves in retirement.

The committee bill, therefore, provides that the first \$50 per month of regular income from any source (other than need-related income) will not be considered in determining eligibility for, or the amount of, the supplemental security payment. In addition, the committee recognizes that some people will continue to work and attempt to be self-supporting long after others would have stopped. These attempts should be encouraged and those who work should find that their work provides a higher level of income than can be had without working.

Accordingly, the committee bill provides that an additional \$85 a month plus \$1 for each \$2 in excess of \$85 in earned income shall be disregarded in determining an individual's (or a couple's) income for

purposes of determining the amount of supplemental security payments for aged, blind or disabled people.

As a result of these exemptions, everyone who qualifies for social security benefits will be assured a monthly income of \$180 for an individual and \$245 for a couple.

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 committee 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 \$130 on the basis of a disability and who lived in the home of his son would have his monthly benefit reduced to \$87 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.

In addition, the committee bill would provide that in determining an individual's income for purposes of supplementary security income payments, any rebate of State or local taxes (such as real property or food taxes) received by an aged, blind or disabled recipient would not be counted as income or assets.

For example, some States provide an income tax credit to elderly homeowners in recognition of the impact which rising property taxes have on those who are retired and living on fixed incomes. If the individual has an income tax liability for the year, the credit is used to offset that liability. Because the supplementary income payment would be based on gross income without regard to the amount of taxes paid the credit represents a real gain in income. If, however, the individual has no income tax liability, the credit may be paid to him in the form of a tax "refund." If the law made no special provision, such a refund would be considered an increase in gross income, which would result in an offsetting reduction in his supplementary income payment and therefore no change in his real income. The committee bill provides for such refunds or rebates to be disregarded so that people who get supplementary income payments and who receive tax refunds will enjoy the same increase in real income as those who get credits against their tax liability.

In line with the committee's desire to provide every opportunity and encouragement to the blind and disabled to return to gainful employment, the new program 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 the 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 make him self-supporting, the money could be excluded if the Secretary approved his plan to establish a business.

The bill also includes a provision under which payments provided on the basis of need by a State or local government (including from Indian tribes) to supplement the Federal benefits provided under this program would be excluded from income.

The new program would provide that unearned income, in addition to other excluded income, of \$60 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.

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.

Excluded resources.—An individual (or an individual and his eligible spouse) with resources in excess of \$2,500 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 and automobile, would be excluded, within limits determined by the Secretary of Health, Education, and Welfare. 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-support, such as the tools of a tradesman, farm machinery, the inventory of a small business and the land surrounding a small rural home.

Life insurance policies would not be counted as resources if the total face value of the policies is not more than \$1,500. In the case of a husband and wife, each could have insurance policies of up to \$1,500 face value. Otherwise, the cash surrender value of an insurance policy would be counted as a resource.

Resources that are readily convertible to cash, such as stocks and bonds, would be counted as a resource in determining whether the assets of the individual (or couple) are within the \$2,500 limit. Income-producing property which is not used as part of a trade or business, would be excluded from the resources limitation only to the extent it is producing a reasonable return. 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 operations of a trade or business and which does not provide a reasonable return should clearly be included as re-

sources. 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.

An individual (or couple) disposing of assets to a relative for less than fair market value will be assumed under the committee bill to have done so for the purpose of qualifying for supplemental security payments and will accordingly be disqualified from receiving such payments for a period of one year.

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 supplemental 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.

Payment of Benefits

While the committee believes that in a program such as it proposes benefits generally should be paid monthly, it recognizes that a few 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.

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.

The bill also provides that payments may be made to individuals initially applying for benefits when there is strong evidence of the likelihood of eligibility and if they are faced 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, disabled applicants could be paid up to 3 months' 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, the 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.

Procedural and Miscellaneous Matters

(a) *Overpayments and underpayments.*—Whenever the Secretary finds that an individual had been paid more than the correct amount of supplemental income he would be authorized to recover the overpayment. 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 eligibility under this program. Underpayments, however, would not be paid to the estate of a deceased individual since that would not further the objective of providing supplemental income to 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 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.*—The 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 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.

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.

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 Supplemental Security Income program.

(d) *Prohibition of assignments; rulemaking authority; subpoena power.*—Any amounts paid or payable under the new program would, like social security benefits, generally be exempt from levy, garnishment, or other legal process. 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 supplemental income that would be provided.

However, the Committee bill provides a specific prohibition against the use of the so-called "declaration method" of establishing eligibility for benefits.

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 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.*—The 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. For example, the records of the Internal Revenue Service would be made available in verifying information as may be needed.

(f) *Fraud.*—The bill would provide a fine of not more than \$1,000, 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) *Annual 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.

(h) *Food stamps and surplus commodities.*—Under the committee bill (as under the House-passed bill), individuals receiving payments under the new program will not be eligible for food stamps; they will also not be eligible for surplus commodities.

(i) *Confidentiality of information.*—Information in the records of the Secretary would generally be held in confidence. However, the bill would direct that any information in his records must be released to the General Accounting Office, Congressional Committees, State legislature committees, State and Federal law enforcement agencies, Federal, State, and local prosecutors and the Immigration and Naturalization Service. Such information would be available, of course, only in connection with the official duties of such officials, and except for a court prosecution or a quasi-judicial administrative proceeding they would be required to maintain the confidentiality of the information.

(j) *Administration.*—In the course of the deliberations leading up to the committee's decision to recommend the new federally administered program, it became convinced that by utilizing the administrative structure of the Social Security Administration excessive expansion of the Federal bureaucracy could be avoided. There is, however, some apprehension that administration of the new program and the existing social security programs by a single agency could lead to confusion between the new program and the old-age, survivors and disability insurance program. In this regard, the committee reemphasizes the point made in the House report that while a single agency might administer the programs, there is no intent to merge the new supplemental program with the existing social security program. Each is to maintain its own 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.

Because of the practical problems involved in determining how the actual disbursements for administrative expenses should be made when the same officers will be providing services for both the OASDI program and the new Supplemental Security Income program, it may be necessary to make the initial disbursements for administering the new program 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 supplemental 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 undercut 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.

Social Services for the Aged, Blind, and Disabled

The section in chapter IX of this report concerning social services (see pp. 483ff) outlines the provisions of the committee bill providing Federal matching for social services. For beneficiaries of Supplemental Security Income services are provided for in a new title VI of the Social Security Act.

The new title will authorize the provision of rehabilitation and other services to help aged, blind, and disabled individuals to obtain or retain capability for self care, the same definition as in existing law. Federal matching for these services will be subject to the limits the Congress will soon be acting upon which are contained in the Conference Committee substitute for the Senate amendment to the State and Local Fiscal Assistance Act of 1972.

Under the substitute, Federal matching for social services under programs of aid to the aged, blind, and disabled and aid to families with dependent children would be subject to a State-by-State dollar limitation effective beginning fiscal year 1973. Each State would be limited to its share of \$2,500,000,000 based on its proportion of population in the United States. Child care services, services provided to a mentally retarded individual, services related to the treatment of drug addicts and alcoholics, and services provided a child in foster care could be provided to persons formerly on welfare or likely to become dependent on welfare as well as present recipients of welfare. At least 90 percent of expenditures for all other social services, however, would have to be provided to individuals receiving aid to the aged, blind, and disabled or aid to families with dependent children. Until a State reaches the limitation on Federal matching, 75 percent Federal matching would continue to be applicable for social services as under present law.

Puerto Rico, Guam, and the Virgin Islands would continue under the provisions and funding limitations of existing law as to social services.

Medicaid Coverage

Under present law, the States are required to cover all cash assistance recipients under the medicaid program. The committee bill, like the House-passed bill, would exempt from this requirement persons who are eligible for Supplemental Security Income but would not have been eligible for assistance under the State welfare programs for the aged, blind, and disabled as they were in effect prior to the initiation of this new program.

Effective Date

The provisions of the committee bill establishing a new supplemental security income program for the aged, blind, and disabled are effective January 1, 1974.

Amendments to the Program of Aid to the Aged, Blind, and Disabled

The new Federal Supplemental Security Income program will not be effective until January 1, 1974, in order to allow the Department of Health, Education, and Welfare ample lead-time to prepare for the administrative tasks involved. Until this date, the current State administered programs of aid to the aged, blind, and disabled will remain in effect.

Many of the amendments which the Committee bill makes in the program of Aid to Families with Dependent Children are designed to give the State greater flexibility in administering that program and would be equally useful in the administration of aid to the aged, blind, and disabled. Accordingly the Committee bill makes a number of temporary amendments to those programs to be effective during calendar year 1973. These amendments are listed below. A more complete description of each of them is given in the chapter on Aid to Families with Dependent Children at the pages indicated.

In providing social services to the aged, blind, and disabled, each State would be authorized to utilize either the same organizational unit as administers cash assistance or a different unit as it determines best. States would be permitted to require persons requesting copies of manuals and other policy issuances to pay the costs involved. The Committee bill would authorize the States to terminate assistance to persons who have been out of the State for 90 days. (See chapter IX.)

Under certain conditions vendor payments for rent could be made to recipients' landlords and rent payments for recipients in public housing could be combined in a single check payable to the Housing Authority. Under at least one court decision, welfare agencies have been required to continue assistance payments to a recipient who has been found ineligible even after the finding was affirmed at an evidentiary hearing at the local level pending a further appeal to a hearing at the State level. The Committee bill would authorize States to put the findings of an evidentiary hearing at the local level into effect immediately. (See chapter IX.) The Committee bill would make clear that the requirement that welfare information be kept confidential may not be used to prevent public officials from obtaining information they require in connection with their official duties. The bill would allow the Secretary of Health, Education, and Welfare in appropriate cases to waive the requirement that social services be provided on a state-wide basis. This provision would become a permanent part of the new title VI program of services for the aged, supplemental income program starting in 1974.

In addition, the committee bill would make applicable to the State programs of aid to the aged, blind, and disabled for 1973 the same provisions with respect to drug addicts and alcoholics which the committee has adopted for the aid to families with dependent children and the Supplemental Security Income programs. In general, addicts and

alcoholics would be ineligible for assistance but would be referred to the new alcoholism and addiction program established by the bill as title XV of the Social Security Act.

TABLE 1.—OLD-AGE ASSISTANCE: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972

	Aged individual		Aged couple	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
Alabama.....	\$158	\$115	\$266	\$230
Alaska.....	250	250	350	350
Arizona.....	118	118	164	164
Arkansas.....	149	105	210	210
California.....	183	183	330	330
Colorado.....	145	145	290	290
Connecticut.....	238	238	286	286
Delaware.....	140	140	197	197
District of Columbia.....	113	113	158	158
Florida.....	121	121	160	160
Georgia.....	102	96	159	159
Hawaii.....	132	132	205	205
Idaho.....	182	182	219	219
Illinois.....	173	173	214	214
Indiana.....	185	80	247	160
Iowa.....	117	117	178	178
Kansas.....	203	203	247	247
Kentucky.....	96	96	160	160
Louisiana.....	147	100	235	188
Maine.....	123	115	214	214
Maryland.....	96	96	131	131
Massachusetts.....	189	189	280	280
Michigan.....	184	184	237	237
Minnesota.....	158	158	230	230
Mississippi.....	150	75	218	150
Missouri.....	181	85	247	170
Montana.....	111	111	175	175
Nebraska.....	182	182	235	235
Nevada.....	170	170	271	271

TABLE 1.—**OLD-AGE ASSISTANCE: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972**—Continued

	Aged individual		Aged couple	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
New Hampshire.....	\$173	\$173	\$228	\$228
New Jersey.....	162	162	222	222
New Mexico.....	116	116	155	155
New York.....	184	184	234	234
North Carolina.....	115	115	153	153
North Dakota.....	125	125	190	190
Ohio.....	126	126	212	212
Oklahoma.....	130	130	212	212
Oregon.....	122	122	177	177
Pennsylvania.....	138	138	208	208
Rhode Island.....	163	163	211	211
South Carolina.....	87	87	121	121
South Dakota.....	180	180	220	220
Tennessee.....	102	97	194	142
Texas.....	119	119	192	192
Utah.....	112	112	150	150
Vermont.....	177	177	233	233
Virginia.....	152	152	199	199
Washington.....	149	149	214	214
West Virginia.....	123	123	156	156
Wisconsin.....	175	175	241	241
Wyoming.....	139	104	195	178

TABLE 2.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972

	Blind individual		Disabled individual	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
Alabama.....	\$125	\$125	\$71	\$71
Alaska.....	250	250	250	250
Arizona.....	118	118	118	118
Arkansas.....	149	105	149	105
California.....	198	198	177	177
Colorado.....	105	105	123	123
Connecticut.....	238	238	238	238
Delaware.....	189	150	117	117
District of Columbia.....	113	113	113	113
Florida.....	121	121	121	121
Georgia.....	102	96	100	96
Hawaii.....	132	132	132	132
Idaho.....	182	182	182	182
Illinois.....	173	173	173	173
Indiana.....	185	125	185	80
Iowa.....	144	144	117	117
Kansas.....	203	203	203	203
Kentucky.....	96	96	96	96
Louisiana.....	106	101	99	66
Maine.....	123	115	123	115
Maryland.....	96	96	96	96
Massachusetts.....	180	180	178	178
Michigan.....	184	184	184	184
Minnesota.....	158	158	158	158
Mississippi.....	150	75	150	75
Missouri.....	255	100	170	80
Montana.....	123	123	111	111
Nebraska.....	182	182	182	182
Nevada.....	155	155	(¹)	(¹)
New Hampshire.....	173	173	173	173
New Jersey.....	162	162	162	162
New Mexico.....	116	116	116	116
New York.....	184	184	184	184

TABLE 2.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, JULY 1972—Continued

	Blind individual		Disabled individual	
	Income eligibility level for payments	Largest amount paid for basic needs	Income eligibility level for payments	Largest amount paid for basic needs
North Carolina.....	\$120	\$120	\$115	\$115
North Dakota.....	125	125	125	125
Ohio.....	126	126	116	116
Oklahoma.....	130	130	130	130
Oregon.....	163	163	122	122
Pennsylvania.....	150	150	138	138
Rhode Island.....	163	163	163	163
South Carolina.....	103	95	87	80
South Dakota.....	180	180	180	180
Tennessee.....	102	97	102	97
Texas.....	110	110	110	105
Utah.....	122	122	112	122
Vermont.....	177	177	177	177
Virginia.....	153	153	152	152
Washington.....	149	149	149	149
West Virginia.....	123	123	123	123
Wisconsin.....	175	175	175	175
Wyoming.....	139	104	127	104

¹ No program.

TABLE 3.—NUMBER OF PERSONS AGED 65 OR OVER RECEIVING OASDI CASH BENEFITS, OAA MONEY PAYMENTS, OR BOTH, BY STATE, FEBRUARY 1972 ¹

State	Number				Number per 1,000 aged population			
	Unduplicated total	OASDI ²	OAA	Both OASDI and OAA	Unduplicated total	OASDI ²	OAA	Both OASDI and OAA
Total.....	18,700,668	17,961,700	2,014,815	1,275,847	891	856	96	61
Alabama.....	312,616	274,000	112,882	74,266	919	806	332	218
Alaska.....	6,374	5,600	1,947	1,173	911	800	278	168
Arizona.....	155,507	150,000	13,376	7,869	879	847	76	44
Arkansas.....	226,821	206,000	58,179	37,358	922	837	237	152
California.....	1,667,889	1,601,000	314,033	247,144	898	862	169	133
Colorado.....	168,510	164,000	31,083	26,573	855	832	158	135
Connecticut.....	263,660	261,000	8,130	5,470	891	882	27	18
Delaware.....	41,932	41,000	2,806	1,874	932	911	62	42
District of Columbia.....	52,922	51,100	4,023	2,201	756	730	57	31
Florida.....	910,060	888,000	55,719	33,659	849	828	52	31
Georgia.....	349,747	308,000	90,728	48,981	911	802	236	128
Hawaii.....	43,696	42,700	2,744	1,748	910	890	57	36
Idaho.....	66,020	64,900	3,319	2,199	917	901	46	31
Illinois.....	975,479	958,000	33,879	16,400	876	860	30	15
Indiana.....	457,842	453,000	15,974	11,132	905	895	32	22

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Iowa.....	326,937	319,000	21,840	13,903	911	889	61	39
Kansas.....	243,137	239,000	9,195	5,058	891	875	34	19
Kentucky.....	316,017	292,000	57,892	33,875	898	830	164	96
Louisiana.....	284,168	243,000	114,836	73,668	891	762	360	231
Maine.....	110,720	108,000	10,786	8,066	946	923	92	69
Maryland.....	262,778	258,000	9,523	4,745	842	827	31	15
Massachusetts.....	564,197	550,000	57,432	43,235	868	846	88	67
Michigan.....	728,212	712,000	41,569	25,357	938	918	54	33
Minnesota.....	378,806	372,000	17,063	10,257	891	875	40	24
Mississippi.....	215,294	186,000	81,538	52,244	936	809	355	227
Missouri.....	514,789	487,000	93,682	65,893	891	843	162	114
Montana.....	63,844	62,700	3,240	2,096	899	883	46	30
Nebraska.....	167,708	165,000	7,239	4,531	878	864	38	24
Nevada.....	29,087	28,400	2,959	2,272	881	861	90	69
New Hampshire.....	75,853	74,800	4,594	3,541	925	912	56	43
New Jersey.....	632,467	626,000	19,657	13,190	876	867	27	18
New Mexico.....	67,843	63,200	8,533	3,890	905	843	114	52
New York.....	1,774,353	1,734,000	110,741	70,388	883	863	55	35
North Carolina.....	400,500	381,000	35,202	15,702	919	874	81	36
North Dakota.....	63,432	61,900	3,700	2,168	919	897	54	31
Ohio.....	905,679	883,000	51,033	28,354	887	865	50	28
Oklahoma.....	282,017	253,000	67,124	38,107	901	808	214	122
Oregon.....	217,681	215,000	7,528	4,847	911	900	31	20
Pennsylvania.....	1,159,946	1,139,000	50,230	29,284	889	873	38	22
Puerto Rico.....	162,193	142,000	20,536	343	867	759	110	2

TABLE 3.—NUMBER OF PERSONS AGED 65 OR OVER RECEIVING OASDI CASH BENEFITS, OAA MONEY PAYMENTS, OR BOTH, BY STATE, FEBRUARY 1972 ¹—Continued

State	Number				Number per 1,000 aged population			
	Unduplicated total	OASDI ²	OAA	Both OASDI and OAA	Unduplicated total	OASDI ²	OAA	Both OASDI and OAA
Rhode Island.....	96,354	94,900	3,899	2,445	900	887	36	23
South Carolina.....	184,680	172,000	17,467	4,787	923	860	87	24
South Dakota.....	76,544	74,900	3,678	2,034	922	902	44	25
Tennessee.....	360,904	337,000	49,337	25,433	902	842	123	64
Texas.....	918,534	834,000	209,916	125,382	877	797	200	120
Utah.....	71,807	70,300	2,849	1,342	865	847	34	16
Vermont.....	45,413	44,200	4,151	2,938	927	902	85	60
Virgin Islands.....	2,213	1,900	325	12	922	792	135	5
Virginia.....	332,075	325,000	14,211	7,136	872	853	37	19
Washington.....	306,696	300,000	19,189	12,493	929	909	58	38
West Virginia.....	181,964	175,000	12,205	5,241	901	866	60	26
Wisconsin.....	449,101	442,000	19,695	12,594	920	906	40	26
Wyoming.....	27,650	27,200	1,399	949	864	850	44	30

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¹ Does not include Guam; data not reported.

² State data estimated as of Jan. 31, 1972, by the Social Security Administration.

Costs

The new Federal program as a substitute for the present assistance programs for needy aged, blind, and disabled result in increased Federal expenditures as shown in table 4.

**TABLE 4.—FEDERAL COSTS FOR THE AGED, BLIND,
AND DISABLED, 1974**

[In millions of dollars]

Present law:	
Welfare payments.....	\$2.1
Administration.....	.2
Food stamps.....	.3
Total.....	<u>2.6</u>
Committee bill increases:	
Supplemental security income payments (including cashing out food stamps).....	3.1
Administration.....	.3
Food stamps.....	-.3
Total increase.....	<u>+3.1</u>

**VII. GUARANTEED JOB OPPORTUNITY
FOR FAMILIES**

(405)

Guaranteed Job Opportunity for Families

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VII. GUARANTEED JOB OPPORTUNITY FOR FAMILIES

(Part B of title IV of the bill, establishing a new title XX of the Social Security Act)

The whole Nation has become increasingly concerned at the rapid growth of the welfare rolls in recent years, and with good reason.

By far the major factor in this growth has been the increase in the number of persons receiving Aid to Families with Dependent Children. From 5.3 million recipients at the end of 1967, the number of AFDC recipients doubled during the next four years. The soaring costs of this program have forced States to shift funds into welfare that would otherwise go for education, health, housing and other pressing social needs. There is universal agreement that something must be done, but there remains much confusion about the nature of the problem that must be solved. The committee feels that a more expensive and expansive welfare program is *not* the answer.

The soaring welfare rolls reflect three developments.

First, they show that there are a large number of children in this country who are needy and whose parents in most cases are not working.

Second, they show an alarming increase in dependency on the taxpayer. The proportion of children in this country who are receiving AFDC has climbed sharply, from three percent in the mid-fifties to nine percent today. This means that an increasing number of families are becoming dependent on welfare and staying dependent on welfare.

Third, the growth in the AFDC rolls reflects increasing family breakup and increasing failure to form families in the first place. Births out of wedlock, particularly to teenage mothers, have increased sharply in the past decade. Two striking statistics highlight the problem: the number of families headed by women increased by 15 percent between 1970 and 1971, while the number of families with both father and mother present declined in absolute numbers during the same one-year period. Today, almost 8 million women and children receive welfare because of the "absence of the father from the home"—principally due to family breakup or failure of the father to marry the mother of his child.

Many persons who strongly advocate increasing welfare benefits have simply glossed over the problem of family breakup and the increase of births out of wedlock. Even more importantly, they have avoided discussing the problem of increasing dependency.

In an article that appeared in the *New York Magazine* in October 1971, Nathan Glazer raises the fundamental question of what increasing dependency on welfare has done for recipients in New York City:

Has it reduced starvation and given them more food? Has it improved their housing? Has it improved their environment? Has it improved their clothing? Has it heightened their self-respect

and sense of power? Has it better and more effectively incorporated them into the economic and political life of the city? . . . Blanche Bernstein, director of research at the New School's Center for New York City Affairs, has estimated that 50 percent of the increase in welfare recipients in New York City during the 1960's was due to desertion and 25 percent was due to illegitimate births. She reports that in 1961 there were 12,000 deserted families on welfare in New York City. By 1968 there were 80,000. What happened in New York City was not an explosion in welfare alone. The city witnessed an explosion in desertion and in illegitimacy. . . .

Welfare, along with those who pressed its expansion, deprived the poor of New York of what was for them—as for the poor who preceded them—the best and indeed only way to the improvement of their condition, the way that involved commitment to work and the strengthening of family ties. In place of this, the advocates of revolution through welfare explosion propagated a false and demeaning sense of the “rights” of the poor, one which had disastrous consequences . . .

Relief is necessary to the poor. In any civilized society it must be given generously, and if needed, extensively. But it should be the aim of every society to find and encourage other means to the maintenance of a decent standard of living than the distribution of charity. For whatever the position of modern advocates of welfare rights, welfare can never, if given regularly on an extensive scale, be other than alms, and whatever alms did for the souls of those who gave them, they could not be good for the souls of those who received them. Every society—capitalist, socialist, or “welfare state”—tries to find ways to replace money relief and to make it unnecessary. To advocate its expansion as a means of dealing with distress is one thing; to advocate its expansion as a means of breaking the commitment to work with its attendant effects on self-respect and on family life is irresponsible.

The fundamental problem is raised somewhat differently in an article entitled “Welfare: the Best of Intentions, the Worst of Results” that appeared in the August, 1971, issue of *Atlantic Magazine*. The author, Irving Kristol, begins by quoting from the 19th century social commentator Alexis de Tocqueville:

“There are two incentives to work: the need to live and the desire to improve the conditions of life. Experience has proven that the majority of men can be sufficiently motivated to work only by the first of these incentives. The second is only effective with a small minority. . . . A law which gives all the poor a right to public aid, whatever the origin of their poverty, weakens or destroys the first stimulant and leaves only the second intact.”

At this point, we are bound to draw up short and take our leave of Tocqueville. Such gloomy conclusions, derived from a less than benign view of human nature, do not recommend themselves either to the twentieth-century political imagination or to the American political temperament. We do not like to think that our instincts of social compassion might have dismal consequences—not accidentally but inexorably. We simply cannot believe that the universe is so constituted. We much prefer, if a choice has to be made,

to have a good opinion of mankind and a poor opinion of our socio-economic system. . . .

Somehow, the fact that more poor people are on welfare, receiving more generous payments, does not seem to have made this country a nicer place to live—not even for the poor on welfare, whose condition seems not noticeably better than when they were poor and off welfare. Something appears to have gone wrong: a liberal and compassionate social policy has bred all sorts of unanticipated and perverse consequences. . . .

To raise such questions is to point to the fundamental problems of our welfare system, a vicious circle in which the best of intentions merge into the worse of results.

As Congress examines fundamental questions concerning the effect of dependency on welfare, it must also take note of developments in American society, such as the changing role of women in America and the increasing public demand for action to improve the quality of life in this country.

When the AFDC program was first established under the Social Security Act of 1935, American society generally viewed a mother's role as requiring her to stay at home to take care of her children; she would be considered derelict in her duties if she failed to do so. But values have changed, and today, one-third of all mothers with children under age six are members of the labor force, and *more than half* of the mothers with school-age children only are members of the labor force. This number has been growing steadily in the past 20 years, and it may be expected to continue to grow. In families where the father is not present, two-thirds of the mothers with school-age children are in the labor force.

At the same time, it is widely recognized today that many important tasks in our society remain undone, such as jobs necessary to improve our environment, improve the quality of life in our cities, improve the quality of education in our schools, improve the delivery of health services, and increase public safety in urban areas. The heads of welfare families are qualified to perform many of these tasks. Yet welfare pays persons not to work and penalizes them if they do work. Does it make sense to pay millions of persons not to work at a time when so many vital jobs go undone? Can this Nation treat mothers of school-age children on welfare as though they were unemployable and pay them to remain at home when more than half of mothers with school-age children in the general population are already working?

It is the committee's conclusion that paying an employable person a benefit based on need, the essence of the welfare approach, has not worked. It has not decreased dependency—it has increased it. It has not encouraged work—it has discouraged it. It has not added to the dignity of the lives of recipients, but it has aroused the indignation of the taxpayers who must pay for it.

As President Nixon has stated:

In the final analysis, we cannot talk our way out of poverty; we cannot legislate our way out of poverty; but this Nation can work its way out of poverty. What America needs now is not more welfare, but more "workfare". . . . This would be the effect of the transformation of welfare into "workfare," a new work-rewarding program.

The committee agrees that the only way to meet the economic needs of poor persons while at the same time decreasing rather than increasing their dependency is to reward work directly by increasing its value. The committee bill seeks to put the President's words into practice by:

- (1) Guaranteeing employable family heads a job opportunity rather than a welfare income; and by
- (2) Increasing the value of work by relating Federal benefits directly to work effort.

The committee found that the House-passed bill would not carry out these objectives. It would not reform the existing welfare system, but would merely expand it; instead of reducing the welfare rolls it would increase them by some fifteen million people in the first year alone. It would not reward work effort but would instead penalize it—more than present law in most cases. It would not provide work for the employable but instead would provide welfare for those who work. Though it would ostensibly separate employables and unemployables, it in fact would provide welfare payments for both categories.

The basic approach of the House bill is to keep on the welfare rolls all of those who are now on and to add to the welfare rolls those who are now working at low incomes. This is welfare expansion, not welfare reform. Having added millions to the welfare rolls the House bill then operates on the hope that those who have been put onto the welfare rolls can be removed through expanded work and training programs. The relatively small work and training programs under present law have failed to have an impact on the growing AFDC rolls—how much more unlikely, then, that expanded work and training programs would have an impact on welfare rolls that have been doubled. The committee bill takes a different approach.

The committee bill will substantially increase Federal expenditures to low-income working persons, but the increased funds that go to them—about \$2.4 billion—will be paid in the form of wages and wage supplements, not in the form of welfare, since the payments will be related to work effort rather than to need. Under the present welfare system and under the House-passed bill, an employed person who cuts his or her working hours in half receives a much higher welfare payment; under the committee bill, a person reducing his or her work effort by half would find the Federal benefits also reduced by half.

Description of Guaranteed Employment Program

Under the guaranteed employment program recommended in the committee bill, persons considered employable would not be eligible to receive their basic income from Aid to Families with Dependent Children but would be eligible on a voluntary basis to participate in a wholly federally financed employment program. Thus, employable family heads would not be eligible for a guaranteed welfare income, but would be guaranteed an opportunity to work.

In the description of the guaranteed job program that follows, it is assumed that the Federal minimum wage will rise to at least \$2.00 per hour.

The following table shows which families would continue to be eligible for welfare and which families would no longer be eligible to receive their basic income from welfare under the committee bill:

<i>Eligible for Welfare</i>	<i>Not Eligible To Receive Basic Income from Welfare</i> ¹
1. Family headed by mother with child under age 6	1. Family headed by able-bodied father
2. Family headed by incapacitated father where mother is not in the home or is caring for father	2. Generally, family headed by mother with no child under age 6
3. Family headed by mother who is ill, incapacitated, or of advanced age	
4. Family headed by mother too remote from an employment program to be able to participate	
5. Family headed by mother attending school full time even if there is no child under age 6	
6. Family headed by mother needed at home to care for disabled family member	
7. Child living with neither parent, together with his caretaker relative(s) (though State may deny welfare if his mother is also receiving welfare)	

An estimated 40 percent or 1.2 million of the 3 million families currently receiving Aid to Families with Dependent Children would have to obtain their basic source of income from employment once the committee bill becomes effective.

All heads of families, whether eligible for welfare or not, as well as heads of families no longer eligible for welfare, could volunteer to participate in the new employment program.

The committee bill provides three basic types of benefit to heads of families:

1. A work bonus equal to 10 percent of wages covered under social security up to a maximum bonus of \$400 annually with reductions in the bonus as the husband's and wife's wages rise above \$4,000.

2. A wage supplement for persons employed at less than \$2.00 per hour (but at least at \$1.50 per hour) equal to three quarters of the difference between the actual wage paid and \$2.00 per hour.

3. A guaranteed job opportunity with a newly established Work Administration paying \$1.50 per hour for 32 hours and with maximum weekly earnings of \$48.

¹ These families would be eligible for State supplementation if the State payment level is over \$2,400 a year for the family and if otherwise eligible under the State requirements.

Work Incentives Under the Program

The program would guarantee each family head an opportunity to earn \$2,400 a year, the same amount as the basic guarantee under the House bill for a family of four. It also strengthens work incentives rather than undermining them, as shown in the tables below.

Tables 1 through 4 show the work incentive effects under the House bill and under the committee bill. In table 1, the three types of employment are compared under the guaranteed employment program. Since the House bill generally contemplates a Federal welfare benefit rather than direct employment by the Federal Government, tables 2, 3, and 4 show welfare benefits for the family if the father earns \$1.50 an hour or \$2.00 an hour in regular employment. The tables also show what happens to total family income under the House bill and the committee bill if the father works 40 hours a week (32 hours a week in the case of guaranteed employment), 20 hours a week (16 hours a week in the case of guaranteed employment), or no hours a week. The sources of income shown are: (a) wages paid by the employer, (b) wages paid by the Government, either as employer or in the form of a wage supplement to the employee (for those in jobs paying between \$1.50 and \$2.00 per hour), and (c) the work bonus equal to 10 percent of wages covered under social security.

Table 1 shows these major points about the committee plan:

(1) Since the participant is paid for working, his wages do not vary with family size. Thus a family with one child would have no economic incentive to have another child. This feature also preserves the principle of equal pay for equal work.

(2) As the employee's rate of pay increases, his total income increases.

(3) As the employee's income rises due to higher pay in a regular job, the cost to the Government decreases: \$1.50-per-hour employment by the Government costs the taxpayer \$48 for a 32-hour week; working 40 hours for a private employer at the same \$1.50 hourly rate gives the employee a \$33 boost in income while cutting the cost to the Government by \$27. Moving to an unsubsidized job at \$2.00 per hour increases the employee's income another \$7 while saving the Government about \$13 more.

(4) The less the employee works, the less he gets. No matter what the type of employment, the employee who works half-time gets half of what he would get if he works full time; he gets no Federal benefit if he fails to work at all.

(5) The value of working is increased rather than decreased. Working 32 hours for the Government is worth \$1.50 per hour; when a private employer pays \$1.50, the value of working to the employee is \$2.02 per hour; and working at \$2.00 per hour is worth \$2.20 per hour to the employee. This will assure that any family head in private employment will receive more than \$2.00 an hour. Under the House bill, by way of contrast, the value of working is decreased rather than increased, since the family would be eligible for welfare benefits if the family head does nothing.

Wage paid by employer	Actual value of 40 hours of employment under—	
	House bill (cents)	Committee bill
\$1.50.....	73	\$2.02
\$2.00.....	¹ 90	2.20

¹ \$1.23 for a family of 2; \$1.04 for a family of 3.

(6) Earnings from other employment do not decrease the wages received for hours worked. Thus an individual able to work in private employment part of the time increases his income and saves the Government money. Virtually no policing mechanism is necessary to check up on his income from work.

TABLE 1.—WORK INCENTIVES UNDER THE COMMITTEE BILL

	Employed by—		
	Government at \$1.50 per hour	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
<i>40 hours worked (32 hours if guaranteed employment):</i>			
Wages paid by—			
Employer.....		\$60.00	\$80.00
Government.....	\$48.00	15.00	.....
Special 10-percent payment.....		6.00	8.00
Total Government payment....	48.00	21.00	8.00
Total income.....	48.00	81.00	88.00
<i>20 hours worked (16 hours if guaranteed employment):</i>			
Wages paid by—			
Employer.....		30.00	40.00
Government.....	24.00	7.50	.....
Special 10-percent payment.....		3.00	4.00
Total Government payment....	24.00	10.50	4.00
Total income.....	24.00	40.50	44.00
No hours worked.....	0	0	0
Hourly value of working.....	1.50	2.02	2.20

Work Disincentives Under Present Law and Administration Proposal

By way of contrast, under present law a mother who is eligible for welfare is guaranteed a certain monthly income (at a level set by the State) if she has no other source of income; if she begins to work, her welfare payment is reduced. Specifically, though an allowance is made for work expenses, her welfare payment is reduced \$2 for each \$3 earned in excess of \$30 a month. Generally, then, for each dollar earned and reported to the welfare agency, the family's income is increased by only 33 cents.

The House bill uses the same basic approach as present law but substitutes a flat \$60 exemption plus one-third of additional earnings for the present \$30 plus work expenses plus one-third of additional earnings. The disincentive effects of this are clearly illustrated in the following examples of the effect of the House bill on the income of a family of 4 as shown in table 2:

(1) The less the individual works, the more the Government pays. For example, an individual working at \$2.00 per hour for 20 hours receives \$26.60 more in welfare than an individual working 40 hours a week at that wage; if he does not work at all, his government benefit goes up by \$44.10.

(2) An individual cutting back on his work effort decreases his income by a relatively smaller amount, or, said another way, the value of work is substantially lower under the House bill than under the committee bill. The total income of an individual working at \$2.00 per hour for 20 hours under the House bill is only about \$13 less than his total income if he works full time at that wage. An individual who works not at all receives only \$36 less than the \$82 received by an individual working 40 hours at \$2.00 an hour.

(3) The value of working is decreased rather than increased. Since the family is eligible for \$46.20 in welfare for doing nothing, the \$29.20 in additional family income for 40 hours of work at \$1.50 per hour amounts to a value of only 73¢ an hour for working. Working 40 hours a week at \$2.00 per hour is worth only 90¢ per hour to the employee.

(4) Earnings from any employment (as well as child support payments), if reported, reduce the benefits received by the family. Tables 3 and 4 similarly show income under the House-passed bill for a family with two members and for a family with three members.

TABLE 2.—WORK DISINCENTIVES UNDER THE HOUSE BILL:
INCOME FOR A **FAMILY OF 4**

	Employed by—	
	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
<i>40 hours worked:</i>		
Wages.....	\$60.00	\$80.00
Welfare.....	15.40	2.10
Total income.....	75.40	82.10
<i>20 hours worked:</i>		
Wages.....	30.00	40.00
Welfare.....	35.40	28.70
Total income.....	65.40	68.70
<i>No hours worked:</i>		
Wages.....	0	0
Welfare.....	46.20	46.20
Total income.....	46.20	46.20
Hourly value of working 40 hours.	.73	.90

TABLE 3.—WORK DISINCENTIVES UNDER THE HOUSE BILL:
INCOME FOR A **FAMILY OF 2**

	Employed by—	
	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
<i>40 hours worked:</i>		
Wages.....	\$60.00	\$80.00
Welfare.....	0	0
Total income.....	60.00	80.00
<i>20 hours worked:</i>		
Wages.....	30.00	40.00
Welfare.....	20.00	13.30
Total income.....	50.00	53.30
<i>No hours worked:</i>		
Wages.....	0	0
Welfare.....	30.80	30.80
Total income.....	30.80	30.80
Hourly value of working for 40 hours..	.73	1.23

TABLE 4.—WORK DISINCENTIVES UNDER THE HOUSE BILL:
INCOME FOR A **FAMILY OF 3**

	Employed by—	
	Private employer at \$1.50 per hour	Private employer at \$2.00 per hour
<i>40 hours worked:</i>		
Wages.....	\$60.00	\$80.00
Welfare.....	7.70	0
Total income.....	67.70	80.00
<i>20 hours worked:</i>		
Wages.....	30.00	40.00
Welfare.....	27.70	21.00
Total income.....	57.70	61.00
<i>No hours worked:</i>		
Wages.....	0	0
Welfare.....	38.50	38.50
Total income.....	38.50	38.50
Hourly value of working 40 hours.....	.73	1.04

In brief, the committee bill would pay more to the person who works more, and save the Government the most money if the individual increases his wages to the \$2.00 per hour level or above. The House-passed bill, by way of contrast, would substantially diminish the value of an individual's work by paying him more if he works less and by allowing him to gain only slightly if his rate of pay is increased.

The committee bill thus provides strong and mutually reinforcing incentives to the individual, the Government, and the employer to move welfare recipients into employment and independence. For the individual every hour worked increases his income; regular work for a private employer increases his income more than guaranteed employment provided by the Government; and work without a Federal wage supplement (that is, work paying \$2.00 per hour or more) increases his income more than lower-paying work with a wage supplement. These incentives for the individual to seek more and higher paying employment are reinforced by incentives for the Government to move him in the same direction. As the individual moves from guaranteed employment to employment with a wage supplement, the Federal cost drops from \$1.50 per hour to 53 cents per hour or less, and as he moves into a job paying at least \$2.00 per hour, the Federal cost drops still further—to 20 cents per hour if his hourly wage is \$2.00, decreasing to zero by the time his hourly wage reaches \$2.80. Similarly, the incentives for employment which the individual and the Government have under the committee bill are further reinforced by incentives for private employers to provide such employment since they will qualify for a tax credit of 20 percent of the wages paid for a year (up to a maximum \$800 credit) if they hire participants in the guaranteed employment program.

Elements of Employment Program

KINDS OF EMPLOYMENT

The committee contemplates that the employment program would involve placement in three kinds of employment:

1. Regular employment in the private sector or in jobs in public or nonprofit private agencies;
2. Private or public employment with the employee's wages supplemented; and
3. Newly developed jobs, with the Federal Government bearing the full cost of the salary.

PLACEMENT IN REGULAR EMPLOYMENT

When program participants are ready for employment with little or no preparation, the Work Administration would attempt to place them in regular jobs paying \$2.00 per hour or more (and thus involving no wage supplement). This would be the Work Administration's first priority.

PUBLIC OR PRIVATE EMPLOYMENT WITH WAGE SUPPLEMENT

The next priority would be jobs not covered by the Federal minimum wage law, in which the employer paid less than \$2.00 per hour

but at least \$1.50 per hour. No supplement would be paid if the employer reduced pay for the job because of the supplement. Thus no jobs presently paying the minimum wage would be downgraded under the committee bill, and the minimum wage itself would not be affected. Rather, the supplement relates solely to those jobs not covered under the minimum wage law. Some of these include:

Small retail stores:	Outside salesmen in any industry.
Sales clerk	Public sector:
Cashier	Recreation aide
Cleanup man	Swimming pool attendant
Small service establishments:	Park service worker
Beautician assistant	Environmental control aide
Waiter	Ecology aide
Waitress	Sanitation aide
Busboy	Library assistant
Cashier	Police aide
Cook	Fire department assistant
Porter	Social welfare service aide
Chambermaid	Family planning aide
Counterman	Child care assistant
Domestic service:	Consumer protection aide
Gardener	Caretaker
Handyman	Home for the aged employee
Cook	Agricultural labor:
Household aide	Jobs picking, grading, sorting, and grading crops;
Child attendant	spraying, fertilizing, and
Attendant for aged or disabled person	other preparatory work;
	milking cows; caring for livestock

For these jobs, the Federal Government would make a payment to any employee who is the head of a household equal to three quarters of the difference between what the employer pays him and \$2.00 per hour, for up to 40 hours a week. Thus if an employer paid \$1.50 an hour the Federal supplement would amount to 38 cents an hour (three-quarters of the 50-cent difference between \$1.50 and \$2.00). This wage supplement would be administered by the local office of the Work Administration.

GUARANTEED EMPLOYMENT

For persons who could not be placed in either regular, public or private employment (with or without a wage supplement), the Work Administration would provide employment which would pay at the rate of \$1.50 per hour. An individual could work up to 32 hours a week (an annual rate of about \$2,400), and would be paid on the basis of hours worked just as in any other job. There would be no pay for hours not worked.

However, a woman with school-age children would not be required to be away from home during hours that the children are not in school

(unless child care is provided), although she may be asked, in order to earn her wage, to provide after-school care to children other than her own during these hours.

Participants would not be considered Federal employees, nor would they be covered by social security, unemployment compensation or workmen's compensation. The 10 percent special work-bonus would not apply to their salary.

For these individuals who cannot be placed immediately in regular employment at a rate of pay at least equal to the minimum wage, or in employment with a wage supplement, the major emphasis would be on having them perform useful work which can contribute to the betterment of the community. A large number of such activities are currently going undone because of the lack of individuals or funds to do them. With a large body of participants for whom useful work will have to be arranged, many of these community improvement activities could now be done. At the same time, safeguards are provided so that the program meets the goal of opening up new job opportunities and does not simply replace existing employees, whether in the public or private sector.

To this end, the committee bill requires that the Work Administration observe the following criteria in making arrangements with State and local governments and with nonprofit agencies for work projects to be performed by participants in the guaranteed employment program: such work is performed on projects which serve a useful public purpose and do not result either in displacement of regular workers or in the performance of work that would otherwise be performed by employees of public or private agencies, institutions, or organizations. However, the Work Administration could utilize participants in the program on a temporary or project basis to supplement the work of such employees in situations where more workers than those who are normally employed can be effectively used. Thus the job program cannot be used to undermine existing wage standards.

For mothers with younger children particularly, the Work Administration would provide training and other activities designed to improve the quality of life for the children of participants through improvement of home, neighborhood, and other environmental conditions in which the children live. For example, mothers can be trained in skills to improve their homemaking and upgrade the physical conditions in which the children live. This would include cleaning up and beautifying their apartments or homes, perhaps in groups with other participant mothers, as well as training in consumer skills and providing a pleasing home atmosphere with child-centered activities in the home in which the child can join and have fun. Many of these activities could occur in the home and in the neighborhood with other participant mothers to provide a social life for participants as well. A major goal of this type of activity would be to impress upon participants that they have the ability to improve the living conditions of their children and to increase and reward their desire to do so. Participants engaged in this type of activity as part of their employment during the week would be required to report for work to a participant or regular Work Administration employee serving as a supervisor. Since expansion of child care will be an immediate need, a number of mothers will be trained initially in providing good child care.

Temporary employment could be arranged with private employers. During such temporary employment, participants would continue to be transitional employees of the Work Administration: that is, they would continue to be paid by the Work Administration. The employee would be paid the prevailing wage for the job, however, and the Work Administration would bill the private employer for the employee's wages and other costs associated with making those services available. Unlike other forms of transitional employment by the Work Administration, such temporary employment with private employers would be covered under social security if the employment would be covered by social security when performed directly for the employer.

The Work Administration would attempt to the greatest possible extent to place participants in the transitional government employment program into regular permanent employment. The following categories of regular permanent employment are envisioned:

1. Regular employment without a wage supplement;
2. Regular employment with a wage supplement; and
3. Full time employment as staff for the Work Administration.

Employment in any of these categories would pay more than the \$48 paid transitional employees for working a 32-hour week.

The Work Administration will have need for a great number of employees including the following:

1. Administrative employees to determine eligibility, process payments, etc.;
2. Persons to develop employability plans designed to lead participants into regular employment;
3. Staff to wage a massive effort to develop jobs;
4. Supervisors to oversee the work activities of transitional employees;
5. Family planning aides;
6. Persons arranging for supportive services for participants, including child care; and
7. Persons to direct training activities designed to improve the quality of life of children of participants.

Though a number of the Work Administration's employees would have to be recruited from other sources, it is contemplated that a substantial majority would be drawn from participants in the guaranteed employment program.

Any job in the regular economy paying \$1.50 per hour or more, even a part-time job, would yield a greater income than \$1.50 per-hour Government employment and it is anticipated that this will serve as an incentive for participants to seek regular employment. In addition, the cost to the Government would be substantially less for an individual in regular employment.

Like other income from employment, wages under the guaranteed employment program would be treated as taxable income. However, since even a two-member family need not file a tax return if family income is less than \$2,800—considerably in excess of the \$2,400 that can be earned under the program—these wages would never be taxed. For families with more than two members, of course, even higher amounts are tax-exempt, and thus in no case would wages under the guaranteed employment program be taxed.

ELIGIBILITY FOR FEDERALLY FUNDED JOBS

Except as noted below, eligibility to participate in the employment program would be open to all family heads who are U.S. citizens or aliens lawfully admitted for permanent residence with a child under age 18 (or under age 21 and attending school full time). Participation would be purely voluntary. Mothers with children under age 6 who are eligible for welfare would also be eligible to participate in the guaranteed employment program if they so choose and if child care is available.

Only one member of a family would be eligible to participate in the work program, the head of the household. This would be deemed to be the father unless he is dead, absent, or incapacitated, in which case it would be deemed to be the mother. If neither father nor mother is in the household, a relative undertaking to provide for the child would be eligible to participate.

A head of a household would not be permitted to participate in the employment program as a \$1.50-per-hour Government employee if he or she:

- (1) is a substantially full time student;
- (2) is unemployed because of a strike or lockout, but this disqualification would not apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off workers because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the Government from indirectly subsidizing one side of a labor-management dispute;
- (3) is receiving unemployment compensation;
- (4) is a single person or is a member of a couple with no child under age 18 (or under age 21 and attending school full time); or
- (5) has left employment without good cause or been discharged for misconduct during the prior 60 days. The Work Administration would be authorized to extend the disqualification to as much as six months for individuals who are discharged because of malicious misconduct or for the commission of a crime against their employer.

In addition:

- (6) a family would be ineligible if it has unearned income in excess of \$250 monthly or if total family income exceeds \$5,600 annually; and
- (7) if an individual is able to find regular employment on a part-time basis, he or she will be guaranteed an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours of work per week. In addition to this guarantee, if an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, if the Work Administration

tion has sufficient work available, an individual working full time for the Government under the employment program could work an additional 20 hours with no reduction in the number of hours of Government employment he or she is provided.

Participation in the work program would also be conditioned on compliance with State child labor laws. No work by minors that would be ordinarily prohibited under such laws would be permitted in the Federal program. Moreover, the committee expects that in the case of children who are of such an age that a work permit is required as a condition of their employment, the States would ordinarily not issue such permits with respect to work under this guaranteed employment program.

WORK BONUS FOR LOW-INCOME WORKERS

Low-income workers in regular employment who head families would be eligible for a work bonus equal to 10 percent of their wages taxed under the social security (or railroad retirement) program, if the total income of the husband and wife is \$4,000 or less. For families where the husband's and wife's total income exceeds \$4,000, the work bonus would be equal to \$400 minus one-quarter of the amount by which this income exceeds \$4,000. Thus there would be no work bonus once total income reaches \$5,600 (\$5,600 exceeds \$4,000 by \$1,600; one-quarter of \$1,600 is \$400, which subtracted from \$400 equals zero).

The work bonus could be taken as a tax credit when an individual files his annual tax return (this would most likely be done if an individual is entitled to only a small payment). However, the bonus could be applied for on a quarterly basis if the family's entitlement (either for the quarter or cumulatively) exceeds \$30. For example, a family head earning \$2.00 per hour (where the family has no other income) would be eligible for about \$75 quarterly, and he could apply for and receive the bonus quarterly. If the family head earns \$100 a week (and the family has no other income), annual income will total \$5,200 and he will be entitled to a work bonus of \$100 annually (\$5,200 exceeds \$4,000 by \$1,200; one-quarter of \$1,200 is \$300, which subtracted from \$400 leaves \$100). In this case, he may receive \$50 after the end of the second quarter and \$50 after the end of the fourth quarter since his entitlement in each of the first and third quarters is less than \$30.

The size of the work bonus is shown on the table below for selected examples:

Annual income of husband and wife (assuming it is all taxed under social security)	Work bonus
\$2,000	\$200
3,000	300
4,000	400
5,000	150
5,600	0

The work bonus described above incorporates the features of (1) not varying benefits by family size, but only by income, providing no eco-

conomic incentive for having additional children; and (2) having a gradual phaseout of the amount of the payment as income rises above \$4,000 so as not to create a work disincentive.

The committee bill would apply the 10 percent work bonus only to earnings taxed under the social security and railroad retirement programs. The bonus thus may be viewed as a kind of rebate of these taxes for low-income workers (including a substantial portion of the tax paid by the employer on the employee's wages). However, the employer would continue to withhold social security taxes from the employee's earnings for deposit into the trust funds, and the employee would continue to receive credit for these earnings for social security purposes—in other words, the social security program would not be affected in any way by the work bonus.

There are certain types of work which are covered under social security but only when the amount of wages earned from a single employer exceeds \$50 in a quarter. This limitation applies to the employment of domestics, yardmen and other similar non-business employees. Such employees (if they are still heads of a family) would get the work bonus with respect to all of their wages including those not covered by social security because of the \$50 quarterly limitation. In order to qualify for the work bonus on these wages, however, the individual would have to arrange to perform the work as an employee of the Work Administration which would pay him the prevailing wage for the job and bill the private employer for the wages and other costs associated with making his services available. If the employment would ordinarily be covered by social security, then it will be covered under social security when arranged on this basis by the Work Administration. If the employment is not covered by social security, then the employer will not have to pay social security taxes. In either case, there will be a Federal record of all such wages on which the payment of the work bonus may be based.

The 10 percent work bonus would be administered by the Internal Revenue Service.

TRANSPORTATION ASSISTANCE

In recognition of the fact that a major reason for low-skilled jobs going unfilled in metropolitan areas is the difficulty an individual faces getting to the potential job, the Work Administration would be authorized to arrange for transportation assistance where this is necessary to place its employees in regular jobs. For example, the Work Administration might determine the upper limit of transportation time to get to a job—say, 45 minutes or one hour, depending on the average commuting time in the area. If the individual can get to the job within that amount of time through ordinary public transportation or other arrangements, then he would be expected to do so. If this could not be done, however, then the Work Administration would be authorized to provide transportation directly to employees who could be placed in regular jobs in order to cut the transportation time down to the standard. The Work Administration could only do this where it is necessary in order to increase employment opportunities. In any case, the cost would ordinarily not be borne by the Government—either the employer would pay the Work Administration, or the employee would pay the Work Administration, and perhaps be

reimbursed by the employer if this is customary in the area for the type of job involved. The Work Administration would have the flexibility to absorb some of the costs involved in unusual circumstances.

INSTITUTIONAL TRAINING

Participants in the guaranteed employment program would be eligible to volunteer for training to improve their skills under the training program administered by the Work Administration. The individual would be accepted for enrollment to the extent funds are available and only if the Work Administration is satisfied that the individual is:

1. Capable of completing training; and
2. Able to become independent through employment at the end of the training and as a result of the training.

Employees under the employment program who wished to participate in training would have to be strongly motivated, for they would be paid only \$1.25 rather than \$1.50 for each hour of training. Each hour of training would be treated as an hour of guaranteed employment, except for the rate of pay. Following the successful completion of training (which could not exceed 1 year in duration), the trainee would receive a lump-sum bonus for having completed training equal to 10 percent of the total training stipends he has received while he was in training.

SUPPORTIVE SERVICES

Since the purpose of the proposal is to improve the quality of life for children and their families, any member of a family whose head participates in the guaranteed employment program could be provided services to strengthen family life or reduce dependency, to the extent funds are available to pay for the services. Open-ended funding would be provided for family planning, and for child care services for families with school-age children only (for families with children under age 6, child care services would be provided to the extent funds are available). The agency administering the employment program would refer family members to other agencies in arranging for the provision of social and other services which they do not provide directly. For example, a disabled family member might be referred to the vocational rehabilitation agency, or a 16-year-old out-of-school youth might be referred to an appropriate work or training program, even though the cost of the services themselves would not be borne by the employment program. Other services needed to continue in employment, including minor medical needs, could be provided by the Work Administration.

Former participants in the guaranteed employment program would have access to free family planning services and to child care on a wholly or partly subsidized basis, depending on family income and availability of appropriated funds.

STATE SUPPLEMENTATION

In order to prevent the State welfare program from undermining the objectives of the employment program the State would have to assume for the purposes of their AFDC program that families which include an employable parent (including a mother with no child under

age 6) are actually participating full time in the employment program and thus receiving \$200 per month. For example, if a State ordinarily pays \$250 per month to an AFDC family of four headed by a mother with at least one child under age 6, the State would pay \$50 per month to a similar family of four with no child under age 6. A similar rule would apply to mothers with children under age 6 who volunteer to participate in the employment program.

Furthermore, the State would be required to disregard any earnings between \$200 a month and \$375 a month (the amount an employee would earn working 40 hours a week at \$2.00 per hour) to ensure that the incentive system of the employment program is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of \$200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at \$1.50 per hour.

INELIGIBILITY FOR FOOD STAMPS AND SURPLUS COMMODITIES

Individuals participating in the employment program would not be eligible to participate in the food stamp or surplus commodity programs. However, States would be reimbursed the full cost of adjusting any supplementary benefits they might decide to give to participants so as to make up for the loss of food stamp eligibility. In order to avoid having States provide assistance to an entirely new category of recipient not now eligible for federally-shared Aid to Families with Dependent Children, the committee provided that the Work Administration would pay families headed by an able-bodied father the amount equal to the value of food stamps (but only to the extent that the State provides cash instead of food stamps for families which are now in the Aid to Families with Dependent Children category).

JOB PLACEMENT STANDARDS

The committee bill is designed to stimulate job opportunities in the private sector; it also contains penalties for refusing to accept these jobs. The Work Administration would prepare an employability plan for each transitional employee. Based on the transitional employee's skills, qualifications, experience, and desires, the Work Administration would attempt to direct the employability plan toward employment in an area of interest to the transitional employee, and employment which offers the greatest possibility of self-support. However, participants in the employment program would not be allowed to continue in guaranteed employment if an opportunity for regular employment is available. After one month on the job, an individual could request not to continue in that employment. The request would be handled by an appeals group which would include other participants in the employment program. The participant would not have the right to reject an employment opportunity beforehand. The pen-

alty for failure to take available regular employment would be suspension of the right to participate in the guaranteed employment program, for one day for the first time, one week for the second (including a second rejection of the same opportunity), and one month for the third and succeeding times.

CHILDREN OF MOTHERS REFUSING TO PARTICIPATE IN THE EMPLOYMENT PROGRAM

Under the employment program, mothers in families with no children under age six would generally be ineligible to receive their basic income from the Aid to Families with Dependent Children program. However, such mothers would be assured an opportunity for employment such as to maintain their income at a level above or equal to that which a comparable size family with a child under age 6 gets from welfare alone. It is, of course, possible that in some few instances the mother will ignore the welfare of her children and refuse to take advantage of the employment opportunity. To prevent the children from suffering because of such neglect on the part of their mother, the Work Administration would make payment to the family for up to one month during which time the mother would be provided counseling and other services aimed at persuading her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to a vocational rehabilitation agency; or, if she is not found to be incapacitated, the State would arrange for protective payments to a third party to ensure that the needs of the children are provided for.

EMPLOYMENT PROGRAM IN PUERTO RICO

Certain provisions relating to the employment program in Puerto Rico are included in the committee bill. These modifications are necessary because of the fact that Puerto Rico has a different minimum wage structure than the rest of the United States, has substantially lower per capita income, and has a high rate of unemployment. Under the committee bill the wages paid to Government employees would be equal to three-quarters of the lowest minimum wage applicable to a significant percentage of the population. This would result in a lower wage for guaranteed employment than in the rest of the United States, but it would be significantly higher than current welfare payments in Puerto Rico. The wage supplement program is designed to provide additional income for family heads who are working in jobs not covered by and paying less than the minimum wage. This program is based on the situation prevailing in the United States in which there is the same Federal minimum wage rate for most jobs to which any minimum wage is applicable. Because of the variety of minimum wage rates in Puerto Rico, however, the committee believes that a similar wage supplement program would not be appropriate there. However, the 10-percent work bonus for low-income earners in jobs covered by social security would apply to Puerto Rico under the same conditions as in the rest of the United States.

Tax Credit to Develop Jobs in the Private Sector

Under the present tax law, an employer hiring a participant in the Work Incentive Program is eligible for a tax credit equal to 20 percent of the employee's wages during the first 12 months of employment. The credit is recaptured if the employer does not retain the employee for at least one additional year (unless the employee voluntarily leaves or is terminated for good cause). This tax credit approach will be continued under the new guaranteed employment program.

The guaranteed job opportunity program, unlike the Work Incentive Program, would be open to the head of any family with children. The committee therefore added the following limitations to the provisions of the tax credit to ensure that the credit meets the primary aim of expanding employment opportunities for participants in the committee's work program :

1. The credit would apply only with respect to individuals who have been participating in the guaranteed job program for at least one month ;
2. The credit would not be applicable with respect to more than 15 percent of all employees of the employer in any one year (though the employer would always be permitted to take the credit for at least one employee) ;
3. The credit would not be available with respect to an employee who replaces an employee discharged without good cause ; and
4. The credit could not exceed \$800 in the case of any one employee (20 percent of \$4,000, approximately the amount of annual earnings at \$2 an hour).

In order to create additional employment opportunities for participants in the guaranteed job program, the committee bill would extend the credit to private individuals hiring participants to perform work not related to a trade or business. (An employer taking the credit would not be eligible at the same time for the income tax child care or household expense deduction.) While this provision of the bill would provide a credit worth up to \$800 to the employer, it would save the Federal Government \$4,800 in wages under the work program during the two-year period. Thus the \$800 credit may actually represent a \$4,000 savings in Federal expenditures.

Administration of the Employment Program

A new Work Administration would be created with the responsibility of administering the employment program and paying the wage supplement. The Work Administration's goals would be (1) to improve the quality of life of the children of participating families, (2) to place participants in regular employment, and (3) until this is possible, to serve as transitional employer of participants with the objective of preparing participants for and placing them in regular employment at the earliest possible time.

On the national level, the Work Administration would be headed by a three-member board appointed by the President with the advice and consent of the Senate. A 15-member national advisory committee (with representatives from industry, organized labor, State and local governments, nonprofit employers, social service organizations, minority groups, etc.) would make policy recommendations to the board.

The actual operations of the Work Administration would be locally based, with the bulk of the local employees being persons who are currently participating or who were former participants in the guaranteed employment program. On the local level, the Work Administration would be organized along the same lines as the national office. Coordination with other local service agencies, local government, and local employers, labor organizations, etc., and their cooperation would be critical to the success of local operations.

The local Work Administration office would hire individuals applying to participate, would develop employability plans for participants, engage in job development and job preparation activities, arrange for supportive services needed for persons to participate (utilizing the Work Administration's Bureau of Child Care to arrange for child care services), and operate programs utilizing participants which are designed to improve the quality of life for the children of participants in the employment program.

Effective Dates

The effective date for the basic job opportunity program is January 1974. As of that date, families which include an employable adult (including a mother with no child under age 6) will no longer be eligible for welfare as their basic income. If unable to find a regular job, however, the family head will be guaranteed employment paying \$1.50 an hour for 32 hours weekly, producing \$2,400 of income annually, the same amount which would have been payable to a family of 4 under the House-passed family assistance plan.

The 10 percent work bonus and the wage supplement payment would become payable even before the full guaranteed employment program is operative. Specifically, the work bonus which will be paid quarterly to low-income workers will become effective starting in January 1973. The wage supplement for family heads in regular jobs not covered under the minimum wage law and paying less than \$2.00 per hour will be effective July 1973, utilizing the services of the local employment service offices to make the payments until the Work Administration mechanism is functioning.

VIII. CHILD CARE

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Child Care

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VIII. CHILD CARE

Child Care Services Today

At the present time, the lack of availability of adequate child care represents perhaps the greatest single obstacle in the efforts of poor families, especially those headed by a mother, to work their way out of poverty. It also represents a hinderance to those mothers in families above the poverty line who wish to seek employment for their own self-fulfillment or for the improvement of their family's economic status.

The need for expanding our child care resources reflects the increasing participation of mothers in our Nation's labor force. The number of working mothers has increased more than seven times since 1940, and has more than doubled since 1950. It is estimated that there are today about 12 million women with children under age 18 in the labor force, of whom more than 4 million have children under age six.

The number of women workers is expected to grow rapidly in the years to come. By 1980, it is projected that the labor force will include more than five million mothers with children under age five—an increase of more than 40 percent in the number of such mothers just in the course of this decade.

Such information as we have indicates that many mothers today would be working if they could arrange adequate care for their children. Several studies have shown that lack of child care is a major impediment preventing mothers on welfare from working or participating in employment and training programs. Other studies have reported that a substantial majority of mothers receiving welfare would prefer to work if they could find adequate care for their children. In a study of the employment potential of welfare mothers over the past decade, Perry Levinson of the Department of Health, Education, and Welfare pointed out that with the growth of the AFDC caseload over the past decade, "recipients were more and more women who had stronger educational and occupational backgrounds, that is, high employment potential." However, over 80 percent of the women reportedly could not take jobs because they had children under eight at home, while more than 50 percent lacked child-care facilities.

There is little question that the demand by parents at all economic levels for child care services is great. Unfortunately, the supply is much smaller and is increasing only slowly. The Department of Health, Education, and Welfare estimates that licensed child care facilities today can only accommodate about 700,000 children. As a result, many thousands of children are either left with no supervision whatever or are placed in facilities which do not provide care of adequate quality.

The Committee on Finance has long been involved in issues relating to child care. The committee has been dealing with child care as a seg-

ment of the child welfare program under the Social Security Act since the original enactment of the legislation in 1935. Over the years, authorizations for child welfare funds were increased in legislation acted on by the committee. In legislation acted on in 1962, the committee placed new emphasis on child care services for the children of working mothers through a specific earmarking of child welfare funds for the provision of these services.

In the 1967 Social Security Amendments, the committee made what it believed to be a monumental commitment to the expansion of child care services, as part of the Work Incentive Program. Although much less child care has been provided than was anticipated, the fact remains that child care provided with Federal matching under the Social Security Act constitutes the major Federal support for the care of children of working parents today. Through its support of child welfare legislation and programs, the committee has shown its interest, too, in the quality of care which children receive.

As part of its continuing concern for the welfare of families with children who are in need, and in order to provide for the expansion of child care required to enable the new employment program to meet its goal of making present AFDC recipients independent, the committee is proposing a new approach to the problem of expanding the supply of child care services and improving the quality of these services. The committee bill thus establishes within the new Work Administration a Bureau of Child Care with the eventual goal of making child care services available throughout the Nation to the extent they are needed and not supplied under other programs. It is the committee's belief that this new and innovative approach to child care services can make a substantial impact on the Nation's problems of poverty and dependency.

Providing for More Child Care

Though the Congress has provided additional funding for child care in various legislation enacted over the past decade, past approaches have not sufficed to expand the availability of child care services to the extent necessary to meet the Nation's child care needs. Federal funds available for child care under the Social Security Act have gone unused.

A major reason for this failure to utilize the funds available was the lack of administrative organization, initiative and know-how to create and provide child care services, as well as barriers at the local level through licensing and other requirements. In other words, the present method of simply providing Federal matching funds to the States, and hoping that child care will become available, has been disappointing. It has not resulted in the necessary increase in supply.

Most States have had very limited resources to devote to child care and for many, child care services have been given a low priority. A number of State governments are simply not staffed to handle child care services even on a minor scale. Many States which have established licensing requirements do not have the staff to constructively help organizations wishing to establish child care facilities to meet the licensing requirements or even to insure that the requirements are met by licensed facilities.

State and local governments, private voluntary organizations, and private enterprise, while they have done an admirable job in many instances, cannot be expected to broadly expand the availability of child care services without substantial Federal help.

It is for this reason the committee feels a new mechanism is needed, a single organization with both the responsibility and capability of meeting the Nation's child care needs. The organization would be a new Bureau of Child Care, located in the Work Administration. This organization would be able both to make use of the child care resources which now exist, and to promote the creation of new resources through the utilization of the efforts of governmental agencies, private voluntary organizations, and private enterprise.

Establishment of Bureau of Child Care

(Sec. 431 of the bill, establishing a new title XXI of the Social Security Act)

The committee bill would establish a new Bureau of Child Care within the Work Administration whose basic goal would be to arrange for making child care services available throughout the Nation to the extent they are needed. The Bureau has two top priority goals: first, to arrange for child care services to participants in the guaranteed employment program and other low-income working mothers, and second, to arrange for care in facilities providing hours of child care sufficient to meet the child care needs of children whose mothers are employed full time.

The committee bill would authorize \$800 million in appropriations in fiscal year 1973 (and thereafter such sums as the Congress may appropriate) which would be placed in a revolving fund. With these funds the Bureau would begin arranging for child care services. Initially, the Bureau would contract with existing public, nonprofit private, or proprietary facilities providing child care services. The Bureau would also provide technical assistance and advice to groups and organizations interested in setting up child care facilities under contractual relationship with the Bureau. In addition, the Bureau could provide child care services directly in its own facilities. It would be expected that services would be provided directly only where public or private agencies, individuals, or organizations are unable to develop adequate child care.

The funds appropriated by the Congress would permit the Bureau of Child Care to arrange for child care and would also allow the Bureau to subsidize a portion of child care costs for children in low-income families not in employment under the guaranteed job opportunity program where such services are necessary to enable the mother to work. The percentage of costs subsidized would depend on the appropriations, with the Bureau authorized to set up a schedule of subsidy percentages based on family income and the funds available. The fee schedule established for working mothers would incorporate these two elements: (1) the increase in fee related to family income would be reasonably gradual so as not to provide a work disincentive by sharply diminishing the value of each additional dollar earned; and (2) the subsidy would be on a percentage rather than flat

dollar basis so that a mother desiring a more educationally oriented form of child care will receive a higher subsidy if she chooses this kind of child care, but her own contribution to the cost of the more expensive care would also be greater.

Financing Child Care Provided by the Bureau of Child Care

The Bureau would have three sources of funds with which to operate:

1. Appropriations with which to arrange for child care and to subsidize part or all of the cost of child care;
2. Fees paid by parents or on parents' behalf for child care services; and
3. Revenue bonds which could be sold to finance construction of facilities.

The Bureau would set fees for all child care services provided or arranged for; part or all of the fee might come from the subsidy appropriation to the Bureau, as well as from funds of other public or private agencies. The fees together with the subsidies would go into a revolving fund to provide capital for further development of child care services. The fees would have to be set at a reasonable level so that parents desiring to purchase child care can afford them; but the fees would have to be high enough so that together with the subsidies they would fully cover the Bureau's costs in arranging for the care.

If after the first 2 years the development of child care facilities were inadequate to meet the need, the Bureau could obtain funds for capital investment in the construction of new Federal child care facilities or the remodeling of old ones by issuing bonds backed by its future fee collections. Up to \$50 million in bonds could be issued each year beginning with the third year after the Bureau's establishment, with an overall limit of \$250 million on bonds outstanding.

Kinds of Child Care Offered

From the standpoint of parents, the Bureau would provide a convenient source of all kinds of child care services, at reasonable fees, for both preschool and school-age children. Like the Social Security Administration, the Bureau would maintain offices in all larger communities of the Nation, where parents desiring child care services would be able to obtain them through the Bureau either in facilities under contract with the Bureau or directly in Bureau facilities. In either case, the parents could be confident that the child care services were under the supervision of the Bureau and met the standards set forth in the bill.

The committee bill would require the Bureau, to the extent its priorities and funds permit, to make available a wide variety of child care services, some already well known and some unavailable in most places today. For example:

Parents wishing to have their preschool-age children cared for in a home setting among a small group of children under the supervision of a trained adult would be able to select a family day care home.

Parents seeking full day child care in a facility offering a balanced program of education and recreation for preschool-age

children would be able to send their children to a child care center.

Parents primarily interested in an intensive educational experience for their preschool-age children would be able to send their children to nursery schools, kindergartens—where these are not already provided by the school system—or child development centers such as those under the Headstart program.

Parents of school-age children would be able to choose a facility whose hours and programs were patterned to complement the child's day in school. School-age child care could take the form of a recreational program run by the school itself, or it could be offered, like preschool-age child care, under trained adult supervision in a home or in a center.

Parents seeking child care during the summer school vacation period would be able to send their children to day camps or summer camps.

The Bureau would be required to establish temporary or drop-in child care facilities for the parent who requires child care services from time to time while taking courses at a school or university, shopping, or while otherwise engaged.

The Bureau would be required to arrange for at-home child care, for babysitting. This would enable a parent to continue at work if the child became sick or had a brief school vacation. It would also assure the parent of the availability of babysitting during the day as well as in the evening when the parent was absent.

Parents requiring child care services regularly at night would be able to send their children to night care facilities, primarily designed to care for the child during sleeping hours. Nurses, maintenance staff, and persons in other night-time jobs now find it almost impossible to arrange for child care services while they work.

From the wide variety of kinds of care available, parents would be able to choose the kind of child care best fitting their needs and desires.

For parents participating in the guaranteed employment program under the committee bill and who prefer educationally oriented child care, the Bureau would first attempt to arrange for enrollment of children in child care under Headstart or other child development programs in existence in the area. Though the Bureau would not pay for care received in these programs (since Federal funds are already available for such purposes), it would attempt to secure in this way an opportunity for children of mothers in the employment program to receive child development services.

Though the Bureau would make available a number of types of child care, the care would be subsidized by the Federal Government only if it is provided to low-income families, and only if it is necessary to permit the mother to work.

Establishing New Child Care Facilities

The Bureau will depend for its success in expanding the availability of child care services on the efforts of individuals and public and private groups at the local level in establishing child care facilities. It is the committee's hope that local parent groups, churches, and other or-

ganizations will be stimulated to establish child care facilities, including family day care homes and child care centers. Today, such groups must go through cumbersome administrative procedures to establish a child care facility, if indeed they are able to establish one at all.

Under the committee bill, they would merely need to contract with the Bureau for the provision of child care services. If the Bureau is assured that the group can fulfill its commitment, the group will be able to receive advance funding to begin operations. Moreover, certification by the Bureau will replace the present time-consuming approvals required from various agencies at the local level.

Since its priorities will require the Bureau to arrange for the care of school-age children in particular, the committee expects that where appropriate, the Bureau will give consideration to the use of local school systems through arrangements with local educational agencies.

If the Bureau is in particular need of child care facilities in an area and facilities exist but are of low quality, the Bureau might contract with the understanding that the facility will be promptly improved. If the promised improvement does not take place, the Bureau would be expected either to contract elsewhere or to provide child care services directly in the future rather than to continue to contract for services in a facility of low quality.

Child care services organized by parents or run with extensive parent participation have shown great promise in raising the educational level of disadvantaged children in deprived areas. Often, however, such groups are curbed or stopped in their efforts to set up child care facilities by unnecessarily rigid licensing requirements, cumbersome procedures, or lack of initial operating expenses. For them, the Bureau will represent a source of both technical assistance and initial funding, making it possible for groups interested in promoting parent involvement to establish child care facilities through the Bureau where they are unable to do so today.

Training of Child Care Personnel

It is unfortunate that lack of trained personnel has hampered efforts to expand child care services in the past.

Training will be one of the major activities of the Bureau in its efforts to make child care more broadly available. In particular, the Bureau will give priority to the training and preparation of mothers participating in the guaranteed employment program and other low income mothers in the provision of child care services. The Bureau would be authorized to conduct, either directly or by contract, training programs to prepare individuals in the child care field. The training provisions in the committee bill will enable the Bureau to accomplish two aims at once: providing new job opportunities, and expanding child care services so that other mothers will have an opportunity for employment. It is through training that the committee hopes for significant improvement in the quality of care offered children.

Construction of Child Care Facilities

Child care services can be greatly expanded through the utilization of existing facilities not now used during the week. Schools often are not used after school hours, churches and Sunday schools are fre-

quently available during the week. Apartment houses, public housing units, office buildings and even factories can serve as convenient child care locations, though they are seldom so used today. The committee bill provides authority for the Bureau to issue revenue bonds for the cost of constructing Federal child care facilities, but construction should be resorted to only when child care services may not otherwise be provided. With other provisions of the bill which enable facilities arranged for through the Bureau to be safe while avoiding unnecessarily stringent local building codes, it should be possible to expand facilities with only sparing resort to the construction authority.

Child Care Standards

Of the millions of children who are not cared for by their parents during the day, well under one million receive care in licensed child care facilities. One of the major goals of the committee bill is to insure that the facilities providing care under the Bureau's auspices meet national child care quality standards which are set forth in the bill.

Many persons have argued that State and local licensing requirements are all too often overly rigid and restrictive—to the point where instead of protecting children, they relegate them to unsupervised and unlicensed care, if indeed any care, while their parents work.

The committee bill includes standards requiring child care facilities to have adequate space, adequate staffing, and adequate health requirements. It avoids overly rigid requirements, in order to allow the Bureau the maximum amount of discretion in evaluating the suitability of an individual facility. The Bureau will have to assure the adequacy of each facility in the context of its location, the type of care provided by the facility, and the age group served by it.

To promote the healthy development of children, parents should be actively involved in their children's progress. The committee bill sets as a Federal standard the requirement that every child care facility provide the parents with an opportunity to meet and consult with the staff concerning the child's development, and an opportunity to observe the child while he is receiving care.

Under the committee bill, the Bureau may not require more adults than are needed to achieve a ratio of:

1. Eight children per adult, if child care is furnished in a *home*;
 2. Ten children per adult if care is furnished in a *child care center*;
- and
3. 25 to 1 for *recreational programs*.

Although the Bureau may not require a lower number of children per adult, it may arrange for care in facilities with less children per adult.

To assure the physical safety of children, the bill requires that facilities (other than homes) must meet the life safety code of the National Fire Protection Association. Homes in which child care is provided must meet requirements adopted by the local area that are applicable to general residential occupancy. This will provide protection for those many children today who are being cared for in unlicensed facilities, the safety of which is unknown.

One of the major administrative tasks of the Bureau will be the monitoring of child care facilities to insure that they meet the Federal standards. The committee bill requires the Bureau to establish an Office of Program Evaluation and Auditing to fulfill this function. Unfortunately, experience under the medicare and medicaid programs has shown that some individuals will abuse Federal programs for personal gain. It will be the job of the Office of Program Evaluation and Auditing to do their utmost to prevent this from happening.

In other provisions of the bill, penalties would be set for fraud or misrepresentation concerning the conditions and operation of a health care facility in order to be certified for participation under the medicare or medicaid programs. The penalty was set at imprisonment for up to 6 months, or a fine of up to \$2,000, or both. To discourage individuals from fraud or misrepresentation concerning a child care facility, a similar penalty is included in the committee bill with respect to child care facilities. In addition, the facility involved will be ineligible to participate in any federally funded or assisted child care program for 2 years following conviction.

Any facility in which child care was provided by the Bureau, whether directly or under contract, would have to meet the Federal standards in the law, but it would not be subject to any licensing or other requirements imposed by States or localities. If any individual, group, State, or locality feels that the fire and safety standards are less protective of the welfare of children than those imposed by State and local ordinances, a hearing procedure is provided.

Requiring facilities to meet only the Federal standards will make it possible for many groups and organizations to establish child care facilities under contract with the Bureau where they cannot now do so because of overly rigid State and local requirements. From the standpoint of the group or individual wishing to establish the facility, this provision would end an administrative nightmare. Today, it can take months to obtain a license for even a perfect child care facility, by the time clearance is obtained from agency after agency at the local level. Under the bill, persons and groups wishing to establish a child care facility would be able to obtain technical assistance from the Bureau; they would have to meet the Federal standards and they would have to be willing to accept children whose fees were partially or wholly paid from Federal funds, in order to contract with the Bureau.

Child Care and Early Childhood Education

An emotional and controversial issue frequently raised in the discussion of child care concerns the position taken by some persons that all child care should provide an early childhood education experience. Without being too specific about the nature of this experience (for example, the Federal interagency day care requirements only state that "the daily activities for each child in the facility must be designed to influence a positive concept of self and motivation, and to enhance his social, cognitive, and communication skills"), early childhood education advocates contrast it with "mere custodial care" that is, care like that provided by mothers in their own home to their own children.

Effectiveness of early childhood educational programs.—Though advocates of early childhood education programs cite the immediate intellectual gains children realize as a result of their participation, evaluations of the programs have been virtually unanimous in agreeing that the gains are short-lived. For example, in a summary of recent research on early childhood development issued by the National Institute of Mental Health in 1970, the authors noted the “consistent findings of a dropoff of the gains achieved in the short-term programs when these programs are terminated. . . . Almost all the studies in the literature show a decline in performance after the short-term programs are ended for the children. . . . The evidence is fairly clear that the gains of programs that are of a short term are gains that fail to last. . . . There is no evidence . . . that pre-school instruction has lasting effects upon mental growth and development.”

In an article entitled “The Environmental Mystique” that appeared in the magazine *Childhood Education* in 1970, Dr. Edward Zigler, Director of the Office of Child Development in the Department of Health, Education, and Welfare, stated:

Learning is an inherent feature of being a human being. The only meaningful question, therefore, is not “*Why* do children learn?” but, “*Why* is it that some children do not learn?” Approached in this way, the problem is not one of getting intelligence into nonlearners but rather of determining the conditions and attitudes that interfere with the natural process of learning. We are all aware that children learned before cognitive theorists told us how and before the invention of talking typewriters. Indeed, children learned before schools of any sort existed. How could this learning have been possible without the formal programming of experiences which we have come to associate with the formal educational process? The answer, I think, is that in his natural state the child is a much more autonomous learner than adherents of the pressure-cooker approach would believe. I am convinced the child does most of his learning on his own and often the way to maximize it is simply to let him alone. He accomplishes some of the most significant learning in his every day interaction with his environment. Learning for the child is, thus, a continuous process and not one limited to the formal instruction and whizbang remedial efforts that have recently captured our attention. . . . Whatever the nature of cognitive development might be, such development has been overemphasized in our current society.

Thus it has been repeatedly found that by the third or fourth grade there is no difference between children who have had preschool educational experience and those who have not. Professor Carl Bereiter, who has devoted his career to the education of young children, drew the following conclusion in a paper presented at Johns Hopkins last year:

It appears that the main thing wrong with day care is that there is not enough of it and the main reason there is not enough of it is that it costs too much. At the same time, those who are professionally dedicated to advancing day care seem to be pressing continually to make it more costly by setting certification requirements for day care workers and by insisting that day care should

be educational and not just high-quality institutionalized baby-sitting.

... Producing a measurable educational effect in young children is far from easy; ... it requires as serious a commitment to curriculum and teaching as does education in older children. I cannot imagine day care centers on a mass basis carrying out educational programs of the kind needed to produce measurable effect. If they cannot do so, then it will prove in the long run a tactical blunder to keep insisting that day care must be educational. Sooner or later those who pay for it will begin demanding to see evidence that educational benefits are being produced, and the evidence will not come forth.

It would seem to me much wiser to seek no more from day care than the sort of high quality custodial care that a child would receive in a well-run home, and to seek ways to achieve this level of care at a cost that would make it reasonable to provide it to all those who need it. One should not have to justify day care on grounds that it will make children do better in school any more than one should have to justify a hot lunch program that way.

Educational services for school-age children.—It is anticipated that most of the children receiving child care under the guaranteed employment program in the committee bill will be children who are in school most of the hours of the day for nine months of the year, and who will require supervision only during the hours they are not in school and during vacation periods. There appears to be no reason to require that educational services be provided to a child who already spends six hours a day in school.

In testimony before the Finance Committee, Dr. Zigler stated that for \$80 a year per child an enrichment program could be provided for children receiving child care in family day care homes. Another approach suggested would have children receiving care in family child care homes go to a child care center several times during the week for a more educationally oriented experience at a much lower cost than if they spent full time in the day care center. Thus it should be possible with some imagination to enrich the experience of children who receive care in a home setting while at the same time not adding prohibitively to the cost of child care.

Committee bill.—In view of the considerations discussed above, the committee bill does not require that all child care arranged for by the Bureau of Child Care be educational in nature, nor does it require a formal educational component. However, in arranging for a child's care the Bureau would first have to see if a place is available under a child development program under other legislation if the parent prefers this type of care. Furthermore, educationally oriented child care could be arranged for by the Bureau if fees are available to pay for this kind of care.

Any educationally oriented child care arranged for by the Bureau would have to meet any applicable State or local educational standards, in keeping with the general philosophy of State and local control over education.

Director of the Bureau and National Advisory Council

The Bureau would be headed by a Director appointed by the President with the consent of the Senate. A National Advisory Council on Child Care would be established to provide advice and recommendations to the Director on matters of general policy and with respect to improvements in the administration of the Bureau. The Council would be composed of the Secretary of Health, Education, and Welfare, the Secretary of Labor, the Secretary of Housing and Urban Development, and eight individuals—five of them representative of consumers of child care—appointed by the Director.

Effective Date

The provisions of the committee bill establishing the new Bureau of Child Care would be effective upon enactment.

Grants to States for Establishment of Model Day Care

(Sec. 432 of the bill)

The committee expects that much of the child care offered by the Bureau of Child Care will be similar to that provided by mothers in their own home, since experience has shown that most working mothers prefer family day care because of its convenience and its informality. However, the committee has also provided a 3-year program of grants to States to permit them to develop model child care. Appropriations would be authorized to permit each State in fiscal years 1973, 1974 and 1975 to receive a grant of up to \$400,000 per year to pay all or part of the cost of model care, whether through the establishment of one child care center or a child care system. Special emphasis would be placed on utilizing the model child care for training persons in the field of child care.

**IX. AID TO FAMILIES WITH DEPENDENT CHILDREN,
SOCIAL SERVICES, CHILD WELFARE SERVICES, AND
OTHER PROVISIONS RELATED TO WELFARE PRO-
GRAMS**

Aid to Families With Dependent Children, Social Services, Child Welfare Services, and Other Provisions Related to Welfare Programs

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**IX. AID TO FAMILIES WITH DEPENDENT CHILDREN,
SOCIAL SERVICES, CHILD WELFARE SERVICES, AND
OTHER PROVISIONS RELATED TO WELFARE PRO-
GRAMS**

(Title IV of the bill)

**1. AID TO FAMILIES WITH DEPENDENT CHILDREN AND
SOCIAL SERVICES**

The Developing Problem

The original Social Security Act of 1935 established our Federal-State grant programs which today provide assistance to the aged, blind, and disabled, and to needy families with children. Unlike the federally administered social security program, the welfare titles of the Social Security Act do not set benefit levels nor describe in detail methods of administering the welfare programs; States establish their own assistance programs within the broad guidelines of the Federal law.

Within the past 5 years, however, the Federal-State relationships have undergone substantial change. Three factors have played an important role in the changing relationships:

1. The tremendous growth in the Aid to Families with Dependent Children rolls has created both a fiscal and administrative burden which many States find difficulty coping with.

2. A number of court decisions have had far reaching impact on all aspects of the welfare programs under the Social Security Act. These decisions have used the very broadness of the Federal statute (intended to allow States more latitude) against the States by saying sometimes that anything the Congress did not expressly prohibit it must have intended to require—and sometimes that what the Congress did not expressly permit it must have intended not to permit. This position was explicitly stated by the Supreme Court in *Townsend v. Swank* (opinion dated December 20, 1971), where it was said that “at least in the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a State eligibility standard that excludes persons eligible for assistance under Federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause.”

3. The Department of Health, Education, and Welfare has issued a series of regulations beginning in January 1969, whose effect has been to make it easier to get on welfare and harder to get off welfare, regulations which many States have vigorously, but unsuccessfully, opposed.

The committee bill would make a substantial portion of the present AFDC caseload ineligible to receive its basic income from welfare, and

would instead guarantee an opportunity to earn an income through working. This shift of emphasis from a guaranteed income through welfare to a guaranteed job opportunity should have a significant impact on the future growth of the welfare rolls, but by itself the creation of the work program will not guarantee the integrity of the AFDC program that remains, particularly in view of the factors outlined above.

Various studies conducted by the Department of Health, Education, and Welfare, the General Accounting Office and the States in the past few years have shown that in many States, the welfare programs are not under proper administrative control—as evidenced by an unacceptably high rate of ineligibility, overpayments and underpayments. As a matter of fact, the actions of the Department of Health, Education, and Welfare and the courts in recent years when added together seem to form a broad avenue making it very easy for an individual—ineligible as well as eligible—to find his way onto welfare, and a mystic maze making it very difficult for the welfare agency to get him off of welfare even if ineligible. This pattern of regulations and court action is outlined below:

1. *Use of "simplified declaration" method pushed.*—The Department of Health, Education, and Welfare has required that eligibility for aid to the aged, blind, and disabled be based solely on the individual's statements, without routine verification and investigation of this information. The Department initially wished to require use of the simplified declaration method in Aid to Families with Dependent Children also, but limited its requirement to testing on a sample basis, while strongly encouraging the States to adopt the declaration method for this program (26 States have done so). Even where the simplified declaration method is not used, the Department of Health, Education, and Welfare regulations (45 CFR 206.10(a)(12)) require that in determining initial and continuing eligibility:

Applicants and recipients will be relied upon as the primary source of information in making the decision about their eligibility. . . . Verification of circumstances pertaining to eligibility will be limited to what is reasonably necessary to ensure the legality of expenditures under this program. . . . The agency takes no steps in the exploration of eligibility to which the applicant or recipient does not agree. It obtains specific consent for outside contacts, gives a clear explanation of what information is desired, why it is needed, and how it will be used. . . . When information available from the applicant or recipient is inconclusive and does not support a decision of eligibility, the agency explains to the individual what questions remain and how he can resolve or help to resolve them, what actions the agency can take to resolve them and the need for their resolution if eligibility is to be established or reconfirmed. If the individual is unwilling to have the agency seek verifying information, the agency, unable to determine that eligibility exists, denies or terminates assistance.

2. *Impact of increase in applications on traditional method of determining eligibility.*—In a study of the declaration method

conducted in 1971, the General Accounting Office found that even where the welfare agency was supposed to be using a traditional method of determining eligibility (that is, with routine verification and investigation of information), the crush of the tremendous increase in applications for Aid to Families with Dependent Children resulted as a practical matter in the use of a "simplified declaration" method simply because the agency was too overburdened handling applications to carry out its usual verification procedures.

3. *Welfare payments are estimated.*—The social security benefit an individual receives in a given month is based on his entitlement during the prior month. By way of contrast, welfare payments are based on estimated entitlement during the current month. While this is no problem if an individual has no source of income other than the welfare payment, it means that in most cases the welfare payment will be at least slightly wrong if the recipient has another source of income during the month, such as earnings. Thus, in many cases overpayments and underpayments may result simply from changing circumstances, because entitlement is based on estimated income during the current month.

4. *Hearing required before assistance can be reduced or terminated.*—In 1970 the Supreme Court ruled in two cases (*Goldberg v. Kelly* (397 U.S. 254) and *Wheeler v. Montgomery* (397 U.S. 280)) that assistance payments could not be terminated or reduced before a recipient was afforded an evidentiary hearing, on the constitutional grounds that this would violate the due process clause. The Department of Health, Education, and Welfare regulations (45 CFR 205.10) go much further than the court, requiring agencies to help recipients to request hearings and to tell them of their right to appeal and that welfare payments will continue during the appeal.

5. *Payments must continue during appeal at State level.*—In a recent court case in New Jersey (*Serritella v. Engelman*, opinion dated February 24, 1972), a Federal District Court held that the welfare payment must not only be continued without reduction during the evidentiary hearing at the local level, but must also be continued without reduction during a subsequent appeal at the State level.

6. *Recouping overpayment when recipient is not at fault.*—The regulations of the Department of Health, Education, and Welfare (45 CFR 233.20(a)(3)(ii)(d)) do not permit a State to reduce current welfare payments because of prior overpayments unless the recipient willfully withheld information about income or resources.

7. *Recouping welfare benefits when recipient is at fault.*—The court went even further than the HEW overpayment regulations in *Bradford v. Juras*, when a Federal District Court in Oregon ruled on July 12, 1971 that a State may not reduce current welfare payments when an overpaid AFDC recipient *willfully* withholds information but has no resources apart from the current assistance grant.

8. *Miranda warning required in fraud investigation.*—A new dimension was added to welfare fraud investigation in a recent

New Jersey State Superior Court decision (*New Jersey v. Graves*, April 2, 1971), in which an AFDC recipient had failed to tell the welfare agency that her husband had returned home. The welfare agency investigated and was told by the recipient of her husband's return, without the investigator first advising her of her right to remain silent. This warning was required, the court stated, because:

When defendant was subjected to interrogation by a representative of the fraud division and in the presence of the supervisor of that division, the interrogation had reached an accusatory stage in which she was the target. It is important, also, to note that the circumstances surrounding the investigation contained clear elements of psychological duress, as evidenced by defendant's testimony that she did not notify the welfare board of her husband's return because she was "afraid," presumably of losing some of her benefits.

9. *Supreme Court attitude on protecting State fiscal interest.*— In a recent case (*Townsend v. Swank*, opinion dated December 20, 1971) the Supreme Court did not permit the State of Illinois to distinguish for welfare purposes between students attending vocational schools and students attending other kinds of schools. Particularly significant in the opinion handed down was the court's comment that "a State's interest in preserving the fiscal integrity of its welfare program by economically allocating limited AFDC resources may not be protected by the device of adopting eligibility requirements restricting the class of children made eligible by Federal standards [that is, those eligible under Federal statute and regulations]. That interest may be protected by the State's 'undisputed power to set the level of benefits.'" Thus the court took the position that the only way a State could restrict welfare expenditures was by an across-the-board cut affecting needy persons it considered worthy of assistance as well as other persons the State would have preferred to consider ineligible for assistance.

These pressures from without have led to the welfare programs not being under sufficient administrative control in a number of States. The recent quality control sample of the Department of Health, Education, and Welfare has shown a high rate of ineligibility, overpayment, and underpayment in aid to the aged, blind, and disabled as well as Aid to Families with Dependent Children. The Department has argued that the situation is hopeless and that only direct Federal administration of the welfare programs can result in proper and efficient administration.

The committee does not agree with the Department's attempt at a self-fulfilling prophecy. It is the committee's view that the present Federal-State system would operate much more effectively—as intended by the Congress—if States were relieved of the added burden now placed on them by court decisions and Federal regulations extending welfare eligibility and payments beyond what is contemplated in the statute, and if they were given help in getting at some of the major causes of the increases in the AFDC rolls. This is what the committee has attempted to achieve in the revised version of the AFDC program it is recommending to the Senate.

Outline of the AFDC Program as Modified

The committee bill would recast the Aid to Families with Dependent Children program to clarify its nature as a federally shared program under which States can provide assistance to needy families. Beginning January 1, 1974, families headed by an employable parent would obtain their basic income from employment rather than from welfare. An estimated 40 percent or 1.2 million of the 3 million families currently receiving AFDC would have to obtain their basic source of income from employment beginning on that date.

Conditions of Eligibility

As under existing law, the Federal AFDC statute would limit eligibility to needy families containing at least one child who is under age 18 (or a full-time student under age 21), who is living in the home of his parent or other specified relative, and who has been deprived of support because of the death, absence from the home, or incapacity of a parent. Unlike current law, the AFDC program could not be used to provide the basic income of any family which includes at least one employable parent. In general, any able-bodied father would be considered employable, as would any able-bodied mother heading a family other than one who is caring for a child under age 6 or for another member of the household who is ill or disabled. Federal law would also spell out certain other requirements or limitations on eligibility.

In addition to the Federal requirements, States would be authorized to establish such conditions of eligibility as they might determine to be appropriate to carry out the objectives of the program. For example, States would (as they do now) establish the amount of assets which a family may retain and still receive assistance. Similarly, States could condition eligibility on the fulfillment of certain other requirements not spelled out in Federal law. One such condition might be a requirement that the school-age children in an AFDC family actually attend school. Such conditions would have to be reasonably related to the purposes of the program and could not be used as a subterfuge for changing its basic nature. For example, States could not impose conditions which would have the effect of excluding from AFDC all families with no child under age 3.

In general, then, the Federal law would define the outside limits of eligibility which a State could incorporate in its AFDC program. States would not be required to provide assistance to all families falling within these limits but would, rather, be free to establish reasonable additional conditions or limitations on eligibility.

Level of Assistance and Federal Funding

The committee bill would continue the approach of present law under which each State determines the level of assistance which will be provided to needy families. States could not, however, reduce payment levels to AFDC recipients below \$1,600 for a two-member family, \$2,000 for a three-member family, and \$2,400 for a family of four or more; or if payment levels are already below these amounts they could not be reduced at all.

Unlike present law, Federal funding would not be provided according to a flat percentage (50 to 83 percent, depending upon per capita income in the State) of whatever the State expends for assistance. In-

stead, the Federal Government would make flat grant payments to the States for Aid to Families with Dependent Children which would provide a substantial measure of fiscal relief to the States. The Federal Government would also reimburse the States fully for any additional cash assistance provided to families to offset the loss of food stamps. Families eligible for AFDC would not be eligible for food stamps or surplus commodities. States would be required to assure that families participating in the employment program receive as much in total income as welfare families of similar composition.

Administration and control of AFDC

As under existing law, the AFDC program would be administered by State welfare agencies or by local welfare agencies under the supervision of a State agency. The States would be expected to have greater control over their AFDC programs than is now the case. In the context of the committee's block grant approach, the general authority of the Department of Health, Education, and Welfare to interfere with the States' methods of administration or to impose its regulations on the States would be restricted under the committee bill.

Aid to Families With Dependent Children Under the Committee Bill

The following pages describe the AFDC program as it would be modified under the committee bill. The modifications would be effective January 1, 1973; some further changes would be made once the committee's employment plan became effective on January 1, 1974.

The AFDC program under the committee bill would consist of the following elements:

1. Purpose; authorization of appropriations;
2. General administrative provisions;
3. Eligibility for AFDC;
4. Determining eligibility and amount of benefits;
5. Statutory rights of applicants for and recipients of assistance;
6. Protection of children;
7. Social services;
8. Community work and training programs (effective until January 1974);
9. Relationship with Work Incentive Program (effective until January 1974);
10. Emergency assistance; and
11. Federal financial participation.

Purpose; Authorization of Appropriations

Section 401 of the Social Security Act sets forth the purpose of the AFDC program as follows:

For the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditions in such State, to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life

and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare State plans for aid and services to needy families with children.

As rewritten under the committee bill, the following clarifications would be made in this declaration of purpose to make explicit what the committee feels is now implicit: (1) it would be made clear that welfare is a matter of statutory entitlement rather than a property right; (2) the purpose of aiding children in establishing paternity and obtaining support payments would be an explicit goal of the AFDC program; and (3) the central role of the State in determining the nature of the AFDC program, within the broad outline of Federal law, would be strongly emphasized.

WELFARE AS A STATUTORY RIGHT

A number of court cases have been predicated on the judicial finding that welfare is a property "right" rather than the traditional view that is a "gratuity" granted as a privilege by the Congress and the States subject to such eligibility conditions as are imposed by law.

Benefits under any of the welfare programs are a statutory right, and like any other statutory right, are subject to the establishment of specific conditions and limitations which may be altered or repealed by subsequent legislative action. In fact, the Social Security Act, in section 1104 makes explicit what would be the case in any event, that "the right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress."

The "right to welfare" implies no vested, inherent or inalienable right to benefits. It confers no constitutionally protected benefit on the recipient. To the contrary, the right to welfare is no more substantial, and has no more legal effect, than any other benefit conferred by a generous legislature. The welfare system as we know it today has its legal genesis in the Social Security Act and the statutory rights granted under, and pursuant to, that Act can be extended, restricted, or otherwise altered or amended—or even repealed—by a subsequent act of Congress. It is this ability to change the nature of a statutory right which distinguishes it from a property right or any right considered inviolate under the Constitution. The committee firmly restates this view of the nature of the "right" to a welfare benefit.

RIGHT OF CHILDREN TO HAVE PATERNITY ESTABLISHED AND TO RECEIVE SUPPORT PAYMENTS

The committee is aware of the tendency of many persons involved in the administration of AFDC not to seek the establishment of paternity and support for an AFDC child. Their rationale is that such action may have an adverse effect on the child's mother. But this overlooks the adverse effect on the child of failure to act. The com-

mittee feels that the child must be recognized as a legal person who is in a direct relationship with society and who is not a chastel of his mother. The committee believes that children born out of wedlock have the right to have the identity of their father established, and that all children have the right to be supported by their parents. The committee bill contains a number of provisions concerning this subject, set forth in detail in chapter X of this report (pages 501 ff.) and because of its importance the committee feels that it should be stressed as one of the purposes of the AFDC program.

CENTRAL ROLE OF STATE

It is the committee's view that the present AFDC statute is clear in establishing the central role of the State in determining the nature of its AFDC program, within the broad outline of Federal law. The Department of Health, Education, and Welfare, however, has attempted to severely limit State flexibility with a series of regulations which are more in the nature of legislation than interpretation of the Federal statute. In addition, the courts have used the very broadness of the Federal statute (intended to allow States great latitude in operating their AFDC programs) against the States by taking the position sometimes that anything the Congress did not expressly prohibit it must have intended to require and sometimes that anything the Congress did not expressly permit, it must have intended not to permit. A number of the provisions of the committee bill are designed to deal with problems raised by specific HEW regulations. In addition, the committee bill limits the Department's regulatory authority under the welfare programs so that it may issue regulations only related to specific provisions of the Act, and so that the regulations may not be inconsistent with any provision of the Act. The committee bill would thus free the States to again assume their central role in operating their AFDC programs.

State Plans for Aid and Services To Needy Families With Children

General Administrative Provisions

PROVISIONS IN PRESENT LAW

The present law contains a number of requirements of a general administrative nature related to State AFDC programs, under which they must—

1. Be in effect in all political subdivisions of the State;
2. Provide for financial participation by the State;
3. Designate a single State agency to administer the program or supervise its administration;
4. Be administered by employees selected on a merit basis;
5. Use subprofessional staff and volunteers; and
6. Furnish reports and other information to the Secretary of Health, Education, and Welfare.

These present law provisions are repeated in the committee bill as well, with the one exception that the Secretary would be permitted to waive the requirement of statewideness as it applies to the provi-

sion of social services (this is further discussed below in the section on social services, pages 485-486).

USE OF SOCIAL SECURITY NUMBERS AND OTHER MEANS OF IDENTIFICATION

In its social security provisions, the committee bill contains a procedure designed to introduce additional administrative controls over the issuance of social security numbers and to impose additional penalties for fraudulent use of social security numbers.

In the revised AFDC program under the committee bill (as well as under the other welfare titles of the Social Security Act), applicants for public assistance would be required to furnish their social security numbers to State welfare agencies. These agencies, in turn, are required by the bill to use recipients' social security numbers in the administration of assistance programs.

For example, it is expected that States would use social security numbers for case file identification, for cross-checking purposes, and as an aid in the compilation of statistical data. The committee feels that this provision is a logical extension of the use of social security numbers for identification purposes—a procedure which has proven highly effective as an aid in the administration of the Internal Revenue Code. This use of the social security number for identification purposes on tax returns was adopted at the suggestion of the committee. The committee understands that a number of States have, on their own initiative, undertaken to use social security numbers in this way in administering their welfare programs. The committee believes that the use of this numbering system should contribute to improving the administration of welfare programs and aiding in the detection and prevention of fraudulent practices. It will also permit States to exchange lists of these numbers as an additional safeguard against fraudulent attempts to receive more than one welfare check.

In addition, States would be explicitly authorized in the statute to use photographs and such other means of identification as they desire in administering the welfare programs, and to set penalties for misuse of these means of identification.

SEPARATION OF SERVICES AND ELIGIBILITY DETERMINATION

An example of HEW efforts at legislation through regulation involves the separation of social services from the welfare payment process. On June 2, 1972, the Department of HEW issued a regulation requiring States to have completely separate administrative units handling the provision of social services and handling the determination of eligibility for welfare.

The committee notes that the General Accounting Office in its study of the "simplified declaration" method found that "caseloads in the centers using a simplified method increased disproportionately when . . . they no longer required the same welfare agency worker to determine an applicant's eligibility and also provide social services."

In the committee's view there is little justification for requiring States to make this kind of administrative separation and there are good arguments for not making such a separation at all—in particular, the fact that a good deal of casefinding for services occurs as part of

the eligibility determination process. The committee bill therefore makes it clear that States may not be required to separate the provision of social services from the determination of eligibility under the AFDC program. States which feel that such a separation will contribute to improved administration would be free to separate the two.

ESTABLISHMENT OF ADVISORY COMMITTEES

Regulations issued by the Department of Health, Education, and Welfare in 1969 require States to establish a welfare advisory committee for AFDC and child welfare programs "at the State level and at local levels where the programs are locally administered," with the cost of the advisory committees and their staffs borne by the States (with Federal matching) as part of the cost of administering the welfare programs.

Committee provision.—The committee bill would make the establishment or continuation of such advisory committees optional with the States.

FURNISHING MANUALS AND OTHER POLICY ISSUANCES

Regulations issued by the Department of Health, Education, and Welfare in October 1970 require States to make available current copies of program manuals and other policy issuances related to any of the welfare programs—

without charge to public or university libraries, the local or district offices of the Bureau of Indian Affairs, and welfare or legal services offices or organizations. The material may also be made available, with or without charge, to other groups and to individuals. Wide availability of agency policy materials is recommended.

In addition, the regulations state that:

Upon request, the agency will reproduce without charge the specific policy materials necessary for an applicant or recipient, or his representative, to determine whether a fair hearing should be requested or to prepare for a fair hearing; and will establish policies for reproducing policy materials without charge, or at a charge related to cost, for any individual who requests such material for other purposes (45 CFR 205.70 (b)).

Committee provision.—The committee bill would make clear that States would not be required to furnish these materials without charge, and that States would be permitted to require that the material be made available only at cost.

Eligibility for Aid to Families with Dependent Children

Under present law, Aid to Families with Dependent Children may be furnished to families with children in which a child "has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent." In addition, a State may provide AFDC payments to children who have been deprived of parental support or care by reason of the unemployment of the father. The committee bill would continue these broad categories of eligibility until January 1, 1974, at which time the

following kinds of families would receive their basic income from employment rather than AFDC:

1. A family headed by a father who is not incapacitated;
2. A family headed by a mother (or headed by an incapacitated father where the mother is not providing care to the father) with no child under age 6, unless the mother is (a) ill, incapacitated or of advanced age; (b) too remote from an employment program to be able to participate; (c) needed at home to care for a disabled family member; or (d) attending school full time.

Under the committee bill, States would be required to make eligible for AFDC:

1. A family headed by a mother with a child under age 6;
2. A family headed by an incapacitated father where the mother is not in the home or is caring for the father;
3. A family headed by a mother who is ill, incapacitated, or of advanced age;
4. A family headed by a mother too remote from an employment program to be able to participate;
5. A family headed by a mother attending school full time even if there is no child under age 6;
6. A family headed by a mother who is needed at home to care for a disabled family member; and
7. A child living with neither parent, together with his caretaker relative(s), providing his mother is not also receiving welfare.

However, the following individuals or groups would not be eligible to receive Aid to Families with Dependent Children:

1. Persons residing in a State less than 3 months (however, the former State of residence would continue to provide assistance for the 3 months);
2. Persons who are neither citizens nor aliens lawfully admitted for permanent residence;
3. Persons who have been outside the United States for at least 30 consecutive days but have not yet been back in the United States for 30 consecutive days;
4. Unborn children;
5. Mothers who fail to cooperate in establishing the paternity of a child born out of wedlock and mothers who fail to cooperate in seeking support payments;
6. Persons who are medically determined to be addicts or alcoholics;
7. Individuals receiving another form of federally matched welfare;
8. Until January 1, 1974, persons refusing without good cause to participate in the Work Incentive Program or to accept employment; and
9. Persons who have recently disposed of their assets for the sake of qualifying for welfare.

At the State's option the following additional groups could be excluded from welfare eligibility:

1. Persons absent from the State for more than 3 months;
2. Children living in the same household as their stepfather, and families in which there is a continuing parent-child relationship with a man;

3. Persons who refuse to allow a caseworker in their home;
 4. A child living with a relative when the child's mother is receiving AFDC in another household; and
 5. AFDC children between age 18 and 21 attending school.
 6. A family headed by an unemployed father who is a striker.
- These items are discussed individually below.

DEFINITION OF INCAPACITY UNDER AID TO FAMILIES WITH DEPENDENT CHILDREN

Present law.—Under Aid to Families with Dependent Children, the Federal Government will match payments to families where the father is incapacitated. The definition of “incapacitated” is left up to the States.

Under a regulation issued by the Secretary of Welfare in Pennsylvania, incapacity is defined in a way that allows the State to classify virtually any general assistance recipient with children as incapacitated for purposes of Federal matching. The regulation states:

The determination of incapacity is based on the simple fact of the existence of incapacity and not upon its cause, degree, duration or accompanying factors. It is not necessary to show an affirmative relationship between the incapacity of the parent and the lack of parental support or care. It is immaterial whether the parent was the chief breadwinner or devoted himself or herself primarily to the care of the child, or whether or not the parents were married to each other.

To prove incapacity, there must be proof that a parent has an impairment, but it is not necessary to show that the impairment limits the parent's ability to support or care for the child. . . . The impairment must be proved. If the impairment can be seen, the worker's statement that he has seen it is proof of the existence of the impairment.

Committee provision.—Under the committee bill, the term “incapacitated” would be defined as “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment.” This is the same definition as is used in determining disability under the social security disability insurance program, except that the definition would also apply to short-term, temporary disability while social security benefits are available only to persons whose disability will last at least 12 months. A family head not found to be “incapacitated” under this definition would be assured employment under the guaranteed job opportunity program.

PERSONS RESIDING IN A STATE LESS THAN THREE MONTHS

Present law.—Under the present Federal statute the Secretary of Health, Education, and Welfare may not approve a State plan for Aid to Families with Dependent Children if it includes a duration of residence requirement of more than one year. In the programs of cash assistance for the aged, blind, and disabled, the present statute would permit, in addition to the requirement of one year's residence preceding the date of application, a requirement that the individual have resided in the State for five of the preceding nine years.

In April 1969, the Supreme Court ruled that the duration of residence requirement of the Connecticut and Pennsylvania AFDC programs constituted an action by those States which violated the equal protection clause of the 14th amendment. The Supreme Court stated that the Federal statute "does not approve, much less prescribe, a one-year requirement" and went on to say that even if it were to assume "that Congress did approve the imposition of a one-year waiting period, it is the responsive *State* legislation which infringes constitutional rights." The court further declared that if somehow the constitutionality of the Federal law is involved that "insofar as it permits the one-year waiting-period requirement" it would be unconstitutional because "Congress may not authorize the States to violate the Equal Protection Clause."

This Supreme Court action in outlawing duration of residence requirements may have been one of the factors influencing many States to cut back on their welfare payment levels or not to provide increases as they had in the past. A dissenting member of the Supreme Court noted that "of longer-range importance, the field of welfare assistance is one in which there is a widely recognized need for fresh solutions and consequently for experimentation. Invalidation of welfare residence requirements might have the unfortunate consequence of discouraging the Federal and State governments from establishing unusually generous welfare programs in particular areas on an experimental basis, because of fears that the program would cause an influx of persons seeking higher welfare payments." This Justice concluded that it was "particularly unfortunate that this judicial roadblock to the powers of Congress in this field should occur at the very threshold of the current discussions regarding the 'federalizing' of these aspects of welfare relief."

Committee provision.—The committee bill contains a provision aimed at eliminating the constitutional question raised by the Supreme Court by making it an affirmative requirement of Federal law that the State plan for Aid to Families with Dependent Children include a requirement of three months' residence in the State as a condition of eligibility. (The committee bill, however, would not deny Federal funds to States which by virtue of State law do not in fact impose a duration of residency requirement.) Thus under the committee bill, a three-month duration of residence in a State would, in effect, be a nationally uniform condition of eligibility for assistance. With this structure the question of State violation of the equal protection clause of the 14th amendment is eliminated.

In addition, the committee bill would require a State to continue welfare payments to eligible persons for 3 months after they move to another State unless they become eligible for welfare in the other State earlier than this. The payments themselves would be made by the welfare agency in the new State of residence, with reimbursement made under a cooperative agreement.

ELIGIBILITY OF ALIENS FOR WELFARE; PERSONS OUTSIDE THE UNITED STATES

Present law.—Under the Social Security Act, the Secretary of Health, Education, and Welfare may not approve a State plan of aid

to the aged, blind, or disabled which imposes as a condition of eligibility for welfare "any citizenship requirement which excludes any citizen of the United States" (sections 2(b)(3), 1002(b)(2), 1402(b)(2), and 1602(b)(3)). There is no similar clause in the Federal title relating to Aid to Families with Dependent Children. Thus all the welfare titles of the Social Security Act would permit a State to exclude noncitizens from welfare benefits, although the law does not say so explicitly.

House bill.—For the new program of Federal aid to the aged, blind, and disabled, H.R. 1 as it passed the House would limit eligibility to an individual who "is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence" (section 2014(a)(1)(B)). There is a similar provision under the Family Assistance Program in the House-passed bill.

The House bill also (secs. 2011(f) and 2155(a)(4)(B)) makes an individual ineligible for welfare payments during any month in which the person is outside the United States the entire month; once an individual has been outside the United States at least 30 consecutive days, he must remain in the United States 30 consecutive days before he may again be eligible for welfare.

Court cases.—The Supreme Court on June 14, 1971 (*Graham v. Richardson*) ruled that a State could not condition welfare benefits either upon the applicant being a U.S. citizen or, if an alien, on his having resided in the United States for a specified number of years. Such eligibility requirements were held to violate the Equal Protection Clause of the 14th amendment. As far as the explicit provisions of the Social Security Act were concerned, the Court concluded that they did not affirmatively authorize, much less command, the States to adopt duration of residency requirements or other eligibility restrictions applicable to aliens, but instead merely directed the Secretary not to approve a State plan which excluded U.S. citizens from eligibility. Although the Federal Government admittedly had broad constitutional power to determine what aliens should be admitted to the United States, the period they could remain, and the terms and conditions of their naturalization, the Court felt that the Congress nevertheless did not have the power to authorize the individual States to violate the Equal Protection Clause.

Committee provision.—Under the committee bill this matter would be handled in the same manner as the issue of duration of residency requirements. That is, States would be mandated in Federal law to require as a condition of eligibility for the AFDC welfare program under the Social Security Act (in addition to the 3-month duration of residence requirement) that an individual be a resident of the United States and either a citizen or alien lawfully admitted for permanent residence or a person who is a permanent resident under color of law (that is, a person who entered the United States before July 1948 and who may be eligible for admission for permanent residence at the discretion of the Attorney General under section 1259 of title 8 of the United States Code).

The committee bill also incorporates the provision of the House bill making an individual ineligible for welfare payments if he has been outside the United States at least 30 consecutive days but has not yet been back in the United States for 30 consecutive days.

UNBORN CHILDREN

Present law.—Under the Social Security Act, the term “dependent child” for purposes of Aid to Families with Dependent Children is defined as a needy child “deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent” and who is living with his mother or other relative.

Regulations of the Department of Health, Education, and Welfare permit Federal matching, even if the child has not yet been born. In January 1971, for example, when about 7 million children were receiving Aid to Families with Dependent Children, 53,400 or a little less than 1 percent of the total number of children had not yet been born. About two-fifths of these unborn children were in the State of California alone, where they constituted 2 percent of the recipient caseload.

In a case that came before the New York State Supreme Court in 1971, a woman who had been receiving welfare for her unborn child while pregnant sought a retroactive payment for the second child upon giving birth to twins. Fortunately, in this case, the court ruled against the recipient.

House-passed bill.—In discussing the meaning of “child” under H.R. 1, the House Ways and Means Committee report (p. 184) states:

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.

Committee provision.—The committee bill, like the House bill, would provide that only children who have actually been born would be eligible for Aid to Families with Dependent Children.

COOPERATION OF MOTHER IN IDENTIFYING THE FATHER AND SEEKING SUPPORT PAYMENTS

Present law.—The Congress has written into the Social Security Act a provision requiring the State welfare agency “in the case of a child born out of wedlock who is receiving Aid to Families with Dependent Children, to establish the paternity of such child.”

Court action.—Despite this clear legislative history, a U.S. district court in August 1969 (*Doe v. Shapiro*, 302 F Supp. 761), ruled that a mother’s refusal to name the father of her illegitimate child could not result in denial of Aid to Families with Dependent Children. The applicable State regulation was held to be inconsistent with the provision in Federal law that AFDC be “promptly furnished to all eligible individuals,” on the grounds that the State regulation imposed an additional condition of eligibility not required by Federal law.

The dissenting opinion stated:

Unless the principle of personal parental responsibility is to be abandoned, as an obsolete cornerstone for gauging welfare eligibility, a full disclosure is a necessary and implied governmental prerogative, which requires the applicant to disclose all relevant information. Absent this personal responsibility and cooperative-

ness between the applicant-mother and the government, the effectiveness of the program would be seriously challenged because she is the sole source of this information; and without it the system designed to establish paternity could not function. * * *

Congress created this system which required only the identity of the father to allow enforcement officials with the assistance of the Internal Revenue Service and the social security files, to locate an absconding father. It is one of the very few occasions when the information in those records is statutorily made available for use outside the agencies' official business. Could it be that Congress contemplated this elaborate system would be paralyzed by an uncooperative applicant-mother who could still successfully insist that she be paid her full monetary allotment?

Committee provision.—The committee's answer to this question is an emphatic "No!" The provisions of the committee bill related to child support and establishing paternity are described in greater detail in chapter X of this report (see 501 ff.), but it is appropriate to note here that the committee bill would require, as a condition of eligibility, that a mother cooperate in efforts to establish the paternity of a child born out of wedlock, cooperate in seeking support payments from the father, and assign the right to collect support payments on her behalf to the Government.

DRUG ADDICTS AND ALCOHOLICS

The committee is concerned that substantial numbers of drug addicts and alcoholics today receive welfare payments as disabled or incapacitated individuals, but receive no treatment for their alcoholism or drug addiction. Under the committee bill, persons medically determined to be drug addicts or alcoholics would no longer be eligible for welfare payments except through a program specifically designed for rehabilitation and active treatment. Those provisions are described in greater detail chapter IV of this report (see pp. 299ff.).

INDIVIDUALS RECEIVING ANOTHER FORM OF FEDERALLY MATCHED WELFARE OR BENEFITS FROM THE SUPPLEMENTAL SECURITY INCOME PROGRAM

The committee bill, like present law and the House-passed version of H.R. 1, would make ineligible for welfare under the family welfare program an individual who receives aid to the aged, blind, and disabled or benefits from the Supplemental Security Income program.

RECENT DISPOSAL OF ASSETS

Present law.—Under present law, an individual with assets whose value exceeds the welfare eligibility level in a State may dispose of those assets purposely in order to qualify for assistance.

Committee provision.—Under the committee bill, anyone who has voluntarily assigned or transferred property to a relative within one year prior to applying for aid under one of the public assistance pro-

grams. and who has received less than fair market value for the property, would be ineligible for welfare for a 1-year period (commencing with the date of transfer) on the grounds that he has purposely pauperized himself in order to qualify.

ABSENCE FROM A STATE

Court action.—The Department of Health, Education, and Welfare found the Arizona welfare programs out of compliance in 1971 because the State automatically terminated the welfare eligibility of recipients absent from the State for more than 90 days. The State's policy was contrary not to Federal law (which in no way would preclude the State from doing this) but to HEW regulations which provide that a temporary absence from the State with an intent to return after accomplishing the purpose of the absence shall not interrupt continuation, to require as a condition of eligibility under AFDC welfare payments (45 CFR 233.40).

The State challenged the HEW compliance ruling, but the U.S. Court of Appeals sided with HEW (*Arizona State Department of Public Welfare v. Department of Health, Education, and Welfare*, opinion dated September 14, 1971). The Court found the HEW regulation consistent with the Social Security Act, which did not define residency, and that it was legitimate for the Secretary to exercise his "broad rule-making powers" under section 1102 of the Social Security Act to define residency in such a way as to limit the States' permissible choice of residency requirements. The regulation defining residency, the Court held, was not inconsistent with the letter or spirit of the Social Security Act merely because it held the State to a higher standard.

Committee provision.—The committee bill explicitly permits a State to terminate welfare payments to an individual continuously absent from the State for more than 90 days.

FAMILIES WHERE THERE IS A CONTINUING PARENT-CHILD RELATIONSHIP

Present law.—Under present law, Aid to Families with Dependent Children is available to children who have been deprived of parental support by reason of the "continued absence from the home" of a parent. The so-called "man-in-the-house" or "substitute father" statutes of the States were attempts to define the term "parent" under the Aid to Families with Dependent Children program for eligibility purposes. The State statutes have been varied, some emphasizing cohabitation with the mother as being determinative of the parental relation, while others have required indications of a positive relationship of the man with the child.

Court action.—On June 17, 1968, the Supreme Court ruled that a State could not consider a child ineligible for Aid to Families with Dependent Children when there was a substitute father with no legal obligation to support the child. The Court decision was based on its interpretation of congressional intent as expressed in the Social Security Act and its legislative history. The decision stated: "We believe Congress intended the term 'parent' in section 406(a) of the

Act * * * to include only those persons with a legal duty of support.”

The implication of this decision, as made clear by subsequent cases, was that a State could not deny Aid to Families with Dependent Children even in the situation where there was a stepfather with substantial income.

Committee provision.—The committee believes that a legal obligation to support is too narrow a base upon which to determine eligibility and income accountability for a welfare program for families. Under the committee bill, a State could at its option deny welfare to a child living in the same household as his stepfather. In other cases, the committee feels that the determination whether a man is a “parent” within the meaning of this term in section 406 of the Social Security Act should depend on the total evaluation of his relationship with the child, with the following being positive indications of the existence of such a parental relationship;

(1) The individual and the child are frequently seen together in public;

(2) The individual is the parent of a half-brother or half-sister of the child;

(3) The individual exercises parental control over the child;

(4) The individual makes substantial gifts to the child or to members of his family;

(5) The individual claims the child as a dependent for income tax purposes;

(6) The individual arranges for the care of the child when his mother is ill or absent from the home;

(7) The individual assumes responsibility for the child when there occurs in the child’s life a crisis such as illness or detention by public authorities;

(8) The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;

(9) The individual makes frequent visits to the place of residence of the child; and

(10) The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

The committee amendment specifically states that “such a relationship may be determined to exist in any case only after an evaluation of the [above] factors * * * as well as any evidence which may refute any inference supported by evidence related to such factors.” It is not necessary that all factors be present in a case, nor need they be given identical weight. The important thing in the committee’s judgment is whether the factors indicating a continuing parent-child relationship are more persuasive than factors which tend to refute such a relationship. If they are, then the State may consider the child ineligible.

Under the committee provision, this limitation on AFDC eligibility would be optional with the States. If a State affirmatively exercises its option, however, it would have to comply with this statutory method in determining the child-father relationship.

REFUSAL TO ALLOW CASEWORKERS IN HOME

Court action.—In August 1969, a U.S. district court in New York in the case of *James v. Goldberg* (303 F. Supp. 935) ruled, on constitutional grounds, that New York State could not terminate welfare payments to a recipient who refused to allow a caseworker in her home. The decision stated: "This court cannot with deference to the fourth amendment excuse the absence of a search warrant without a showing by those who seek exemption from the constitutional mandate that the exigencies of the situation make that course imperative. * * * No such showing has been made herein."

On January 12, 1971, the Supreme Court in *Wyman v. James* reversed the lower court's decision, finding that the New York home visit procedure was a reasonable administrative tool serving a valid and proper purpose; it was not an unwarranted invasion of personal privacy but was basically concerned with the child and with any possible exploitation of the child.

Committee provision.—The committee bill would codify the Supreme Court's decision in the statute by permitting the States, at their option, to require as a condition of eligibility under the AFDC welfare program that a recipient allow a caseworker or other duly authorized person to visit the home. In doing so, the committee is not endorsing the so-called "midnight raids," which have been generally considered objectionable as a means of enforcing welfare eligibility rules. The bill specifically requires that such home visits must be made at a reasonable time and with reasonable advance notice.

However, the committee wants to make clear its belief that in "means test" programs, States should have the right to take reasonable steps to establish the facts relating to eligibility. If a State decides that visits by caseworkers to the homes of certain recipients are essential to the establishment of necessary facts, then it should be allowed to provide for these through its laws or regulations. The committee recognizes that there may well be circumstances under which the interests of the welfare recipient and of the Government may best be served by visits of the caseworker to the home.

CHILDREN ABSENT FROM THE HOME

Court action.—On September 14, 1971, a U.S. Court of Appeals agreed with an earlier decision of the Department of Health, Education, and Welfare that the Arizona State plan for Aid to Families with Dependent Children was out of compliance with the Social Security Act. One of the faults found with Arizona's State plan was the requirement that a relative have legal custody of a child living with the relative, when the parent of the child is an AFDC recipient, in order for the relative also to be eligible for AFDC. In effect, the court action made Arizona provide welfare to a child living with a relative even if the child had been loaned to the relative in order to qualify the relative for welfare.

Committee provision.—The committee bill would allow a State to deny aid to a child of a parent receiving Aid to Families with Dependent Children if the child is not living in the same household as the mother and his brothers or sisters but instead is living with another

relative (unless the relative has legal custody of the child). The purpose of this provision of the bill is to prevent a situation in which an AFDC mother can enable a relative to become eligible for welfare by lending the relative one of her children.

Benefits for Strikers

Present law.—The Social Security Act permits a State to provide benefits to a needy child whose father is unemployed, provided that the father is currently registered with the employment office and is not receiving unemployment compensation. Both the Federal law and the regulations of the Department of Health, Education, and Welfare are silent on the question of benefits to strikers.

Court action.—In a recent case in the U.S. District Court of Maryland (*Francis v. Davidson*, opinion dated January 28, 1972) the Court stated that Maryland could not disqualify a family from Aid to Families with Dependent Children on the grounds that the father's unemployment was due to a strike or discharge for cause because this condition of eligibility was in conflict with the HEW regulation which provided that if a State provides benefits to families in which the father is unemployed, it must have a definition of "unemployed father" which includes a father who is employed for less than a stated number of hours. The Court felt there was nothing in the regulation which permitted a State plan to deny welfare benefits on the ground that the father of a needy child was unemployed because he had been discharged for cause or because he was on strike; such a father is clearly unemployed. The Court added that the fact that HEW had itself, by approving the Maryland plan, given approval to the violation of its own regulation in no way relieved Maryland of the requirement that its program be administered in accordance with the HEW regulation. Although great weight is ordinarily given to the interpretation by an administrative agency of its own regulations, the Court noted that once an agency has promulgated a regulation, even in an instance where it is not required to do so, that agency is bound to follow the regulation, particularly where the regulation uses unambiguous and mandatory language. A man out of work because he was discharged for cause or because he was on strike is unemployed; in granting the Secretary of HEW the power to make regulations, the Congress said nothing about fathers unemployed because they were involved in labor disputes. Although the Secretary could have excluded such fathers from the program he chose not to.

By paying benefits to individuals involved in a labor dispute, a State injects the Federal Government into the dispute by providing substantial Federal funds to strikers; the Federal share of such welfare payments is at least 50 percent. A dramatic case in point occurred in Michigan where the number of AFDC recipients in families with an unemployed father increased 75,000 between October and December 1970 during the General Motors strike, with the Federal Government underwriting 50 percent of the payments that went to the strikers. If the District Court decision in Maryland is upheld, welfare benefits to strikers may become mandatory unless the Congress sets a different policy statutorily.

Committee provision.—The Committee bill modifies the unemployed father provision of Aid to Families with Dependent Children so that welfare benefits will not be available for strikers. This disqualification would not apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off workers because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the government financing one side of a labor-management dispute.

Suits to enjoin violation of this provision may be brought by any person deeming himself aggrieved by such violation in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy and without regard to the diversity of citizenship of the parties.

PROVIDING WELFARE PAYMENTS FOR CERTAIN MEMBERS OF AN AFDC HOUSEHOLD

Present law.—Under present law, a State agency may include within the household of a child receiving AFDC “any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid” (section 402(a)(7)).

Committee provision.—The Committee bill provides that AFDC would not be extended to any member of the household who is not either (1) a relative of the child, or (2) a brother or sister of the child and under age 18 (or under 21 and attending school full-time).

Determining Eligibility and Amount of Benefits

Under the committee bill, in the context of the committee’s block grant approach, States would be freed from a number of regulations of the Department of Health, Education, and Welfare which have made it all but impossible for them to protect the integrity of their welfare programs. The provisions of the committee bill relating to determining eligibility and amount of benefits are discussed individually below.

DETERMINING ELIGIBILITY: “DECLARATION METHOD” PROHIBITED

Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant’s home and from other sources. For persons found eligible for assistance, redetermination of eligibility is required at least annually, and similar procedures are followed.

Regulations issued by the Department of Health, Education, and Welfare on January 17, 1969, required States to test a simplified method for the determination of eligibility for welfare in selected areas of the State. The simplified or “declaration method” provides for eligibility determinations to be based to the maximum extent pos-

sible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the case worker. The regulations requiring testing of the declaration method arbitrarily state that a three percent level of ineligibility would be considered "acceptable."

A. Aid to the aged, blind, and disabled.—New regulations issued in 1970 required States to use the simplified declaration method in welfare programs for the aged, blind, and disabled beginning July 1, 1970. The new regulations were justified by the Department of Health, Education, and Welfare on the basis that testing of the declaration method showed conclusively that it did not result in an unacceptable level of ineligibility.

The committee asked the General Accounting Office to look into the testing of the method to see if the results were truly conclusive. In its report, the General Accounting Office found that:

1. The simplified declaration method required by the new Department of Health, Education, and Welfare regulations in fact was pretested almost nowhere; most States actually used oral interviewing or other forms of verification of the information supplied by the applicant;

2. Five-sixths of the total cases tested were simply redeterminations of the eligibility of persons who had previously been subjected to the usual (nondeclaration) application procedures, and thus were not indicative of the manner in which the simplified method would operate; and

3. The sample size under the testing was so small that there is a substantial probability that the ineligibility level exceeded the Department of Health, Education, and Welfare's arbitrary 3-percent "acceptable" level.

B. Aid to Families with Dependent Children.—In 1971, at the committee's request, the General Accounting Office reviewed the testing that had been done of the "simplified declaration" method, this time in the program of Aid to Families with Dependent Children. The General Accounting Office study concluded that welfare centers supposedly using the simplified method started out by using this method in its purest form but soon modified it by conducting personal interviews and by verifying certain eligibility factors:

Without exception, the directors of the centers using the simplified method stated that the centers should not rely completely on applicants' statements as a basis for making eligibility determinations. The directors emphasized that, although they believed that most applicants were honest, eligibility workers had an obligation to assure themselves that their decisions were based on a reasonable amount of evidence that applicants qualified.

The General Accounting Office found that:

1. AFDC caseloads in the centers using a simplified method increased disproportionately (compared to centers using the traditional method of determining eligibility) when the centers first began using the simplified declaration method, that is, before they modified it to include some verification;

2. Caseloads in the simplified method centers increased disproportionately when it was required that the provision of serv-

ices be completely separated from the determination of eligibility;

3. The rate at which applications were disallowed dropped significantly immediately after adopting the simplified method but tended to level off once the simplified method was modified to include personal interviews and verification of certain eligibility factors; and

4. Where local welfare departments made special reviews of the eligibility of recipients who had qualified for assistance under a simplified method, they found that a high percentage of these recipients were ineligible, could not be located, or refused to cooperate. Where data was available—regardless of the method used to determine eligibility—the ineligibility rates either exceeded the 3-percent tolerance level established by HEW or contained many cases where eligibility was questionable.

Study of ineligibility rates.—In January 1972, the Department of Health, Education, and Welfare released a study showing that six percent of a sample of AFDC recipients and five percent of a sample of aged, blind, and disabled individuals receiving welfare were ineligible.

H.R. 1.—Though the House bill gives the Secretary of HEW some latitude in determining eligibility, the Ways and Means Committee report states clearly that committee's attitude about the "simplified declaration" method:

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.* (House Report, p. 161; emphasis in original.)

With regard to verifying information supplied by welfare applicants and recipients, the House report (page 190) states:

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 of a separate eligibility control unit.

Committee provision.—Under the committee bill the declaration method of determining eligibility would be statutorily precluded. When an individual furnishes information in applying for assistance, he correctly assumes that the information he furnishes is subject to verification, with or without his explicit consent, and that other information will be sought to verify his initial or continuing eligibility. The committee bill would require States explicitly in the statute to examine the application or current circumstances of the applicant or recipient and promptly make any verification concerning eligibility factors and other relevant factors from independent or collateral

sources necessary to insure that eligibility exists for all persons in the assistance group and the amount of aid furnished is correct. The Secretary could not by regulation limit the State's authority to verify income or other eligibility factors, or to require reapplication for assistance after a reasonable period.

RECOUPMENT OF OVERPAYMENTS

HEW regulation.—Regulations of the Department of Health, Education, and Welfare preclude the recapture of previous overpayments, regardless of amount, "unless the recipient has income or resources currently available in the amount by which the agency proposes to reduce payment; except that where there is evidence which clearly establishes that a recipient willfully withheld information about his income or resources, such income or resources may be considered in the determination of need to reduce the amount of the assistance payment in current or future periods." (45 CFR 233.20(a)(3)(ii)(d).) This means that only income actually available may be considered when recouping overpayments.

Court action.—A Federal District Court in Oregon went even further than this regulation when it ruled (*Bradford v. Juras*, opinion dated July 12, 1971) that a State may not reduce current welfare payments when an overpaid Aid to Families with Dependent children recipient *willfully* withholds information but has no resources apart from the current assistance grant. The court felt that recoupment from current assistance grants even when the recipient purposefully failed to report income violated the spirit and intent of the statute establishing Aid to Families with Dependent Children and that if the Congress had wanted to allow recoupment from current AFDC grants it would have included an explicit provision in the statute.

Committee provision.—Under the committee bill, this matter would be resolved by providing statutorily that overpayments under the AFDC program constitute an obligation of an individual to be withheld from any future assistance payments or any amounts owed by the Federal Government to the individual (other than death benefits), with the amounts so withheld paid over to the State; in addition, overpayments could also be collected by the States through ordinary collection measures.

INCOME DISREGARDED

Present law.—Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard:

1. All earned income of a child who is a full-time student, or a part-time student who is not a full-time employee; and
2. The first \$30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the

earned income disregard has the effect of keeping people on welfare even after they are working full time at wages well above the poverty line.

Committee provision.—Until January 1974, when the new employment program becomes effective, the committee bill would deal with both of these problems by modifying the earnings disregard formula and by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). Under the committee bill, States would be required to disregard the first \$60 earned monthly by an individual working full time (\$30 in the case of an individual working part time) plus one-third of the next \$300 earned plus one-fifth of amounts earned above this. This differential between full time and part time employment is designed to encourage recipients to move into full time jobs.

In addition, \$20 of child support payments to a family would be disregarded to insure that a family receives a financial benefit when efforts to collect support payments are successful.

Once the employment program under the committee bill becomes effective in January 1974, the earned income exemptions would be replaced by a flat monthly exemption of \$20, applicable to all kinds of income other than child support; in addition, the separate \$20 disregard applicable to child support payments would be continued. With the exception of the amounts disregarded under these two provisions, the AFDC payments for any family would have to be reduced by the amount of their other income. It would be expected that mothers interested in working would receive their work incentives through participating in the employment program established under the committee bill rather than by remaining on welfare.

Income of families participating in the employment program, however, would be treated differently. In order to prevent the State welfare program from undermining the objectives of the Federal guaranteed employment program the State would have to assume for purposes of AFDC or any other welfare program that individuals eligible for the State supplement who are also eligible to participate in the guaranteed employment program (but no longer eligible to receive their basic income from AFDC) are actually participating full time and thus receiving \$200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Furthermore, assuming a Federal minimum wage of at least \$2.00 per hour, the State would be required to disregard any earnings between \$200 a month and \$375 a month (the amount an employee would earn working 40 hours a week at \$2.00 per hour) to ensure that the incentive system of the guaranteed employment program under the committee bill is preserved. These earnings disregards would be a flat requirement; the States would not be required to take into account work expenses. States would be free to treat income above \$375 monthly in any way they wished as long as the first \$375 earned is treated as though it were \$200. The effect of this requirement would be to give a participant in the guaranteed employment program a strong incentive to work full time (since earnings of \$200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working in guaranteed employment at \$1.50 per hour.

The table below shows how wages under the guaranteed employment program would be treated for State welfare purposes:

Hours worked per week.....	None	20	32	40
Hourly wage.....		\$1.50	\$1.50	\$2.00
Approximate actual monthly income.....	0	\$130	\$200	\$375
Income deemed available for State welfare purposes.....	\$200	\$200	\$200	\$200

INELIGIBILITY FOR FOOD STAMPS AND SURPLUS COMMODITIES

Under H.R. 1, individuals eligible for welfare benefits would no longer be eligible to participate in the food stamp program. Under the committee amendment, persons eligible for welfare would similarly not be eligible for food stamps, nor for surplus commodities. However, States would be assured that there would be no additional expense to them if they adjust their welfare payment levels to take into account loss of entitlement to food stamps.

ASSISTANCE LEVELS

Under existing law, each State decides the level of assistance it will provide for AFDC families. The committee bill generally reaffirms the right of the State to make this determination. In moving to a block grant approach which involves substantial fiscal relief, however, the committee feels it is appropriate to require that States could not reduce payment levels to AFDC recipients below \$1,600 for a two-member family, \$2,000 for a three-member family, and \$2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

PAYMENTS FOR RENT

Present law.—In determining eligibility for and the amount of assistance given to a needy family or aged, blind, or disabled individual, a State establishes a needs standard. This standard includes an allowance for rent; some States provide a flat amount for rent in their needs standard, while other States establish a needs standard for items other than rent and then make an allowance for the actual rent paid (generally up to some limit).

Treatment of public housing bonus.—In 1971 a provision was included in a bill extending the authority of the Secretary of Housing and Urban Development with respect to interest rates on insured mortgages (Public Law 92-213, approved December 22, 1971). The amendment which became section 9 of the Public Law in effect amends the welfare law to prevent any welfare agency from reducing welfare payments if there is a reduction in the cost of public housing rent for welfare recipients.

Committee provision.—Inasmuch as welfare payments are intended to provide families with the funds to meet their needs for such items as food, clothing, and shelter, the committee feels that it is entirely appropriate for State welfare agencies to structure welfare payments in proportion to those needs. In the case of shelter in particular, States have found it necessary to use variable allowances because the rents

charged for roughly comparable accommodations may differ considerably. Under such a variable allowance system, while a State may pay more for rent for one family than another, it is actually meeting the needs of the two families equally. If a State were required, as it is under Section 9 of Public Law 92-213, to pay some families in public housing a larger shelter allowance than is necessary to pay their shelter costs, the result would be that such families would receive preferential treatment in comparison with families not in public housing. The committee bill, therefore, reveals the welfare amendment of Public Law 92-213 which requires State to pay a small proportion of welfare recipients rent allowances which exceed rent costs.

In addition, the committee believes that substantial administrative costs could be saved if Federal law permitted States to make vendor payments directly to public housing agencies of the rent portion of welfare payments in the case of recipients living in public housing. The committee bill would permit them to do so.

Present law permits vendor payments to be made to a landlord directly for rent only in cases where a recipient has proven unable to use the welfare funds she receives in the best interests of her children. Yet, failure to make rent payments leads to evictions which are costly to the taxpayers when new housing must be sought on an emergency basis. The committee bill therefore would permit the State under its welfare programs to make a vendor payment for rent directly to a landlord where (a) the welfare recipient had failed to make rent payments for any two consecutive months (whether or not to their current landlord), and (b) the landlord agreed to accept the amount actually allowed by the State to the recipient for shelter as total payment for the rent.

Permitting States To Require Periodic Reapplication for Welfare Benefits

Present law.—Under present regulations of the Department of Health, Education, and Welfare, States are supposed to redetermine the eligibility of each AFDC case at least once every 6 months. However, this is largely pro forma requirement, handled routinely by mail.

Committee provision.—The Committee amendment would permit States to require reapplication for Aid to Families with Dependent Children, if they so wish, once every two years (or less frequently).

Statutory Rights of Applicants for and Recipients of Assistance

RIGHT TO APPLY FOR AND TO RECEIVE AID WITH REASONABLE PROMPTNESS

Present law.—The present law requires that:

All individuals wishing to make application for Aid to Families with Dependent Children shall have opportunity to do so, and that Aid to Families with Dependent Children shall be furnished with reasonable promptness to all eligible individuals.

Committee provision.—The committee bill would reiterate this provision, but would make clear the requirement that aid be furnished "with reasonable promptness" could not be so construed as to interfere with other requirements of the law such as seeking a mother's cooperation in establishing paternity and seeking support payments, or verifying information on income, resources, and other eligibility factors.

APPEALS PROCESS

Present law.—Present law requires that a State plan must provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid is denied or not acted on with reasonable promptness. Regulations of the Department of Health, Education, and Welfare require States to provide a similar opportunity in cases involving reduction or termination of assistance.

Court action: hearing required before welfare payments may be reduced or terminated.—On March 23, 1970, the Supreme Court ruled in two cases (*Goldberg v. Kelly* (397 U.S. 254) and *Wheeler v. Montgomery* (397 U.S. 280)) that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The decision was made on the constitutional grounds that termination of payments before such a hearing would violate the due process clause. The Court argued that welfare payments are a matter of statutory entitlement for persons qualified to receive them, and that “it may be realistic today to regard welfare entitlements as more like ‘property’ than a ‘gratuity.’ * * * The constitutional challenge cannot be answered by an argument that public assistance benefits are ‘a “privilege” and not a “right.”’”

The HEW regulations based on the court’s decision (45 CFR 205.10) go much further than the court in spelling out the requirements for fair hearings. The tone and emphasis of the regulations is shown in these excerpts: “Agency emphasis must be on helping the claimant to submit and process his request, and in preparing his case, if needed. The welfare agency must not only notify the recipient of his right to appeal, it must also notify him that his assistance will be continued during the appeal period if he decides to appeal.” The regulation continues: “prompt, definitive, and final administrative action will be taken within 60 days from the date of the request for a fair hearing, *except where the claimant requests a delay in the hearing*” (emphasis added).

Court action: payments to continue during appeal at State level.—In another recent court decision (*Serritella v. Engelman*, opinion dated February 24, 1972) a Federal District Court in New Jersey issued a preliminary injunction against New Jersey for its policy of reducing or terminating welfare benefits after an evidentiary hearing on the county level instead of continuing assistance without reduction until after a hearing at the State level. The Court based its decision on regulations issued by the Department of Health, Education, and Welfare. When the defense contended that the HEW regulations went much further than the due process standards of the 1970 Supreme Court decision, the Court explained that Section 1102 of the Social Security Act conferred plenary rule-making power upon the Secretary of HEW.

Committee provision.—Under the committee bill. State welfare agencies under any of the welfare programs (or local welfare agencies, if the program is locally administered) would be required to reach a final decision after an evidentiary hearing on the appeal of a welfare recipient within thirty days following the day the recipient is notified of the agency’s intention to reduce or terminate assistance. The bill would also require the repayment to the agency of amounts which a recipient received prior to the appeal decision if

it is determined that the recipient was not entitled to them. Any amounts not repaid would be considered an obligation of the recipient and would be recouped in the same manner as other overpayments.

In addition, the committee bill would stipulate that the recipient has a right to appeal at a higher administrative level in States which provide for such an appeal, but that payments need not be continued once an initial adverse determination has been made on the local level at a hearing in which evidence can be presented.

The committee provision is designed to assure that the appeals procedure is handled expeditiously by the States and also to assure that appeals are not made frivolously.

SAFEGUARDING INFORMATION

Present law.—The statutes in all of the welfare programs under the Social Security Act provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of each welfare program.

HEW regulations.—Regulations issued by the Department of Health, Education, and Welfare on February 27, 1971, limit the disclosure of information concerning applicants and recipients “to purposes directly connected with the administration of the program. Such purposes include establishing eligibility, determining amount of assistance, and providing services for applicants and recipients.” (45 CFR 205.50) The HEW regulations go on to state that “the same policies are applied to requests for information from a governmental authority, the courts, or a law enforcement official as from any other outside source.”

Committee provision.—The committee bill reenacts the statutory provisions but includes an amendment making it clear that this requirement may not be used to prevent public officials from obtaining information they require in connection with their official duties.

Protection of Children

The committee bill includes the provisions of the present program of Aid to Families with Dependent Children relating to child abuse and AFDC payments for foster care. In addition, the committee bill would modify the provision of present law relating to protective payments.

PROTECTIVE PAYMENTS UNDER AID TO FAMILIES WITH DEPENDENT CHILDREN

Present law.—The major concern of the Congress in adopting provision for protective payments was to insure that welfare payments to families are used for the benefit of the needy children in the families. The Social Security Act provides that when the welfare agency has reason to believe that the AFDC payments are not used in the best interest of the child, it “may” provide counseling and guidance services so that the mother will use the payments in the best interests of the child. This failing, the agency “may” resort to protective pay-

ments to a third party who will use the funds for the best interest of the child.

Committee provision.—Under the committee bill this provision of the Social Security Act would be modified to require rather than permit States to take action when AFDC payments are not being used for the best interests of the child.

PROTECTIVE PAYMENTS FOR CHILDREN OF PARENTS INELIGIBLE FOR WELFARE BECAUSE OF REFUSAL TO PARTICIPATE IN THE GUARANTEED JOB OPPORTUNITY PROGRAM OR FOR OTHER REASONS

Present law.—The Federal statute provides that if a welfare recipient refuses without good cause to participate in the Work Incentive Program or refuses an offer of employment, the person making the refusal may no longer be considered a part of the family for welfare purposes. Thus for example a family consisting of a mother with three children would receive a welfare payment as a three-member family (rather than as a four-member family) if the mother refused work or training. However, for a period of 60 days a State may continue payment to the mother if during this period she receives counseling or other services aimed at persuading her to participate in work and training. Protective payments may be made on the children's behalf to another individual who is interested in or concerned with the welfare of the children.

H.R. 1.—The House bill would reduce a family's welfare payment by \$800 if the family head refuses to register or to accept work or training.

Employment program.—Under the committee's employment program, about 40 percent of the present AFDC families would have to obtain their basic source of income from employment. The committee is concerned lest children be cut off from any source of income if a mother is no longer eligible for welfare and does not find a regular job or choose to participate in the employment program. Although it is assumed that this will happen only in a small number of cases, the children must be protected.

Committee provision.—The committee bill would continue the provision of present law until January 1, 1974, when the guaranteed employment program would become effective. At that time, the committee bill would deal with this problem by an approach based in part on present law. Under this approach, if a case of potential child abuse or neglect results because a mother who is ineligible for basic income under AFDC also refuses to participate in the employment program, the Work Administration would be authorized to make payment to the family for up to one month if the mother is provided counseling and other services aimed at persuading her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to a vocational rehabilitation agency; or, if she is not found to be incapacitated, the State could arrange for protective payments to a third party to provide for the needs of the children.

Under the committee bill, protective payments would also be available to a child whose mother is ineligible for welfare because of her

refusal to: (1) cooperate in establishing the paternity of a child or in seeking support payments; (2) allow a caseworker in the home; or (3) accept treatment, if she is a drug addict or alcoholic.

Social Services

PRESENT LAW

Before 1962, services provided to welfare recipients were subject to the same 50% Federal matching as was available for administrative expenses. In order to encourage States to provide social services designed to prevent and reduce dependency on welfare, the Congress in 1962 enacted legislation increasing the Federal matching for social services to 75% while leaving Federal matching for administrative costs at 50%. No definition of social services was included either in the 1962 bill or in the committee reports on the legislation; defining the scope of services was left to the Secretary of Health, Education, and Welfare and the States.

The regulations of the Department of Health, Education, and Welfare require States to provide child care and other services to enable persons to achieve employment and self-sufficiency, foster care services, services to prevent and reduce births out of wedlock, family planning services, protective services for neglected or abused children, services to help families meet their health needs, and specified services to meet particular needs of families and children. In addition, the regulations permit 75% Federal matching for any services considered by the State as assisting members of a family "to attain or retain capability for maximum self-support and personal independence."

In 1971 the Congress enacted legislation increasing to 90% the Federal share of services needed in order for an AFDC recipient to participate in the Work Incentive Program.

RAPID RISE IN FEDERAL FUNDS FOR SOCIAL SERVICES

Like Federal matching for welfare payments, Federal matching for social services under present law is mandatory and open-ended. Every dollar a State spends for social services is matched by three Federal dollars. The Secretary, by law, is given specific authority to limit the contracting authority for social services and to limit the extent of services to potential (as opposed to actual) welfare recipients. In both cases, however, he has failed to establish effective limitations. In fact, the regulations he has promulgated and the actions of HEW regional officials have invited the very expansion which has taken place. In the last two years particularly, States have made use of the lack of limits on social services under the Social Security Act and the Act's open-ended 75 percent matching to pay for many programs previously funded entirely by the States or funded under other Federal grant programs at lower than 75 percent matching.

The Federal share of social services was about three-quarters of a billion dollars in fiscal year 1971, about \$1.5 billion in 1972, and will be an estimated \$4.7 billion for fiscal year 1973. Under present administrative guidelines—or perhaps more correctly lack of guidelines—States have succeeded in financing almost any government activity under this provision. The distribution of social services today seems based

more on a State's aggressiveness and administrative ingenuity than the needs of its recipients of assistance. For example, one State financed a half million dollar TV documentary with social services money. In another State, social service funds have gone into the State highway department, while in still another State, funds are going for advice on personal grooming to potential parolees from the State prisons. State welfare departments, which are supposed to exercise control over these expenditures, are becoming little more than fiscal conduits. Some States have even gone so far as to formally appropriate private funds—like UGF, and so forth—so they will qualify for Federal matching money.

At this point in time when social services expenditures are expanding at very rapid rates—and vary from State to State with no discernible relation to any objective factors—it appears that the Secretary of Health, Education, and Welfare, estopped by his past actions in approving State plans, is now incapable of taking any effective steps which will restore fiscal responsibility.

LIMITATION ON GRANTS TO STATES FOR SOCIAL SERVICES

The Committee incorporates the limitations contained in the conference substitute to the amendment adopted by the Senate to the State and Local Assistance Act of 1972. Under the substitute, Federal matching for social services to the aged, blind and disabled, and those provided under Aid to Families with Dependent Children would be subject to a State-by-State dollar limitation, effective beginning fiscal year 1973. Each State would be limited to its share of \$2,500,000,000 based on its proportion of population in the United States. Child care services, services provided to a mentally retarded individual, services related to the treatment of drug addicts and alcoholics, and services provided a child in foster care could be provided to persons formerly on welfare or likely to become dependent on welfare as well as present recipients of welfare. At least 90 percent of expenditures for all other social services, however, would have to be provided to individuals receiving supplemental security income or Aid to Families with Dependent Children. Until a State reaches the limitation on Federal matching, 75 percent Federal matching would continue to be applicable for social services as under present law. Family planning services under the Committee bill would not be subject to the Federal matching limitation.

Under the Committee bill, services necessary to enable AFDC recipients to participate in the Work Incentive Program would not be subject to the limitation described above; they would continue as under present law, with 90 percent Federal matching and with funding of these services limited to the amounts appropriated. In addition, the Committee bill incorporates the provision of the conference bill reducing Federal matching for emergency social services from 75 percent to 50 percent.

The Committee directs the Secretary of Health, Education, and Welfare to issue regulations prescribing the conditions under which State welfare agencies may purchase services they do not themselves provide, and regulations which clearly state that the State matching requirement cannot be met by funds donated by private sources.

The Committee was told by the Secretary of Health, Education, and Welfare that new regulations will require reporting of how social service funds are used. The Committee expects the Secretary to have available detailed information on how social service funds are being spent and on their effectiveness.

MAKING SEPARATION OF SERVICES AND ELIGIBILITY DETERMINATION OPTIONAL

On June 2, 1972 the Department of HEW issued a regulation requiring States to have completely separate administrative units handling the provision of social services and handling the determination of eligibility for welfare. The issuing of this regulation was justified by the Department on the grounds that the Family Assistance Plan would soon be enacted and it would require a separation of the State-administered services programs from the Federal welfare payment programs. (This action took place three weeks after the committee announced its action not to require separation of services and eligibility determination.) It should be noted that the General Accounting Office in its study of the "simplified declaration" method found that "caseloads in the centers using a simplified method increased disproportionately. It should be noted that the General Accounting Office in its study of the "simplified declaration" method found that "caseloads in the centers using a simplified method increased disproportionately when . . . they no longer required the same welfare agency worker to determine an applicant's eligibility and also provide social services."

Committee provision.—The committee feels that there is little justification for mandating that States make this kind of administrative separation and there are good arguments for not making separation at all—in particular, the fact that a good deal of casefinding for services occurs as part of the eligibility determination process. Under the committee bill, States would not be required to separate the provision of social services from the determination of eligibility for welfare in any of the welfare programs.

ELIMINATING STATUTORY REQUIREMENT OF INDIVIDUAL PROGRAM OF SERVICES FOR EACH FAMILY

Present law requires States to develop an individual program of services for each family receiving AFDC. This has proven to be an unnecessary administrative burden, and the House bill incorporates an amendment deleting this requirement from the law.

Committee provision.—The committee bill, like the House bill, would eliminate the statutory requirement of an individual program of services for each AFDC family.

MODIFYING REQUIREMENT OF STATEWIDENESS FOR SOCIAL SERVICES

Present Law.—The Social Security Act requires that social services (including child care and family planning services) under the welfare programs be in effect in all political subdivisions of a State in order for the State to obtain Federal matching funds. This requirement of Statewideness has sometimes delayed the provision of these services.

Committee provision.—The committee bill, like the House bill, contains a provision permitting the Secretary to waive the requirement of statewideness for services

SERVICES FOR PARTICIPANTS IN THE GUARANTEED JOB OPPORTUNITY PROGRAM

The committee has already agreed that, under its workfare program, services for participants in the employment program would be arranged for by the Work Administration to the extent that they are necessary in order to permit the participant to work. Other social services would not be provided by the Work Administration, but by the State welfare agency on the same basis as they are provided to other low-income families.

Participation in Work and Training Programs

WORK INCENTIVE PROGRAM

The committee's employment program would be effective January 1, 1974. Until then the Work Incentive Program under present law would be continued and States would be permitted to have community work training programs until January 1974 if they wish to do so.

COMMUNITY WORK AND TRAINING PROGRAMS

Present Law.—Prior to the enactment of the Work Incentive Program as part of the 1967 Social Security Amendments, the Federal AFDC statute permitted Federal matching of AFDC payments made to recipients participating in a community work training program. Since the enactment of the WIN program, however, the Department of Health, Education, and Welfare has taken the position that the Federal Government will not share in AFDC payments to recipients who are required by State law to participate in an employment program—unless the program either is part of the Work Incentive Program or is administered under the Economic Opportunity Act. The employment programs for AFDC recipients that have been permitted in California and New York have been funded as demonstration projects.

Committee provision.—Under the committee bill, the community work training provisions in the law prior to the 1967 amendments would be reenacted until January 1, 1974, so that States wishing to have such programs in the interim could do so.

Emergency Assistance

GENERAL

Present Law.—Under existing law, emergency assistance may, at the option of the States, be provided to needy families in crisis situations, and it may be provided either statewide or in part of the State. Emergency assistance programs have been adopted in about half the States, and they receive 50 percent Federal matching. Under the law, assistance may be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources; the payments, care, or services involved are necessary to

avoid destitution of the child or to provide living arrangements for the child; and the destitution or need for living arrangements did not arise because the child or relative refused without good cause to accept employment or training for employment. Assistance could be in the form of money payments, payments in kind, other payments as the State agency may specify, or medical care or any other type of remedial care for the child or other member of the household in which the child is living, and other services as may be specified by the Secretary.

Committee provision.—The committee bill would continue this provision of present law but would add special provisions relating to migrant families with children.

EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES WITH CHILDREN

Under existing law, emergency assistance may be provided needy migrant families either statewide or in part of a State, at the option of the State. The committee believes that there is an urgent need to assist these families and children and that this problem is of a national nature. The committee bill therefore adds a provision: (1) requiring that all States have a program of emergency assistance to migrant families with children; (2) requiring that the program be statewide in application; and (3) providing 75 percent Federal matching for emergency assistance to migrant families.

Federal Financial Participation

Committee provision.—The committee bill would make a major change in the basic method of Federal funding for Aid to Families with Dependent Children by providing a block Federal grant with substantially more Federal funds than are now provided under present law. This new approach is described in detail in chapter XI of this report, dealing with fiscal relief for States (see pp. 535ff.)

Federal funding for social services has been described above. Other provisions relating to Federal matching are described below.

Administration.—As under present law, the Federal Government would pay 50% of the cost of administration of the AFDC program (including administrative costs related to the provision of social services). Under the committee bill, 50 percent Federal matching would also be provided for the cost of State and local efforts to prosecute welfare fraud.

Family planning services.—Under the committee bill the Federal Government would pay 100% of the costs of birth control services (as compared with 75% under present law, or 90% in the case of birth control services required to enable an AFDC recipient to continue to participate in the Work Incentive Program). Those services would not be under the limitation on Federal matching for social services.

Supportive services for participants in the Work Incentive Program.—The committee bill would continue 90% Federal matching for supportive services (other than birth control services, for which 100% Federal matching would be provided) to enable AFDC recipients to participate in the Work Incentive Program. Those services would not be under the limitation on Federal matching for social services. This provision would expire on January 1, 1974 when the Committee's employment program would begin.

Emergency assistance.—As described above, the Federal Government would provide 50% matching for emergency assistance, with 75% matching for emergency assistance to migrant families.

Adjusting payment levels to reflect loss of eligibility for food stamps.—Under the committee bill, AFDC families would no longer be eligible to receive food stamps. The Federal Government would pay 100% of the cost to the States of adjusting their welfare payment levels to reflect loss of eligibility for food stamps.

Lightening the Federal Burden on the States

In addition to the items already mentioned, the committee bill includes several provisions designed to ease a portion of the Federal burden that has been placed on the States.

Section 1102 of the Social Security Act permits the Secretary of Health, Education, and Welfare to “make and publish such rules and regulations, not inconsistent with this act, as may be necessary to the efficient administration of the functions” with which he is charged under the act. Similar authority is provided under each of the welfare programs. Particularly since January 1969, regulations have been issued under this general authority which have no basis in law and which sometimes have run directly counter to legislative history. Many States have attributed at least a part of the growth of the welfare caseload in recent years to these regulations of the Department of HEW.

At the same time that the Department has attempted to create new legislation through its regulations, it has made little effort to insure that the States comply with such provisions of the statute as the requirement that family planning services be offered every appropriate welfare recipient, that the States establish separate units to collect child support payments, or that States terminate welfare payments to individuals refusing without good cause to participate in work and training programs.

Examples of legislative use of general regulatory authority.—The courts have consistently upheld the Secretary’s authority to issue regulations that are essentially legislative. Examples include:

1. Requiring States to use the “simplified declaration” method;
2. Requiring States to pay benefits to persons absent from the State more than 90 days; and
3. Requiring the continuation of unreduced welfare payments during the entire appeals process.

Committee provision.—A number of provisions already mentioned are designed to deal with problems raised by specific regulations issued by the Secretary. In addition, the committee bill would modify Section 1102 of the Social Security Act to limit the Secretary’s regulatory authority under the welfare programs so that he may issue regulations only related to specific provisions of the Act and that the regulations may not be inconsistent with these provisions.

Use of Federal Funds To Undermine Federal Programs

One of the often-stated aims of the Legal Services program of the Office of Economic Opportunity is:

The use of the judicial system and the administrative process to effect changes in laws and institutions which unfairly and adversely affect the poor. (Page 534 of the Narrative Justifications presented by OEO at the Senate fiscal year 1971 Appropriations Hearings on July 20, 1970.)

In carrying out this broad, highly subjective, and basically legislative function, certain Legal Services activities have been aimed directly at undermining the welfare programs—which are, of course, established by duly enacted Federal laws.

For example, a document entitled “Know Your Welfare Rights” prepared by the Tulare County Legal Service Association (paid from Federal poverty funds) stated: “If you don’t want to work there is no reason why welfare can force you to work, no matter what your welfare worker says.” The pamphlet was subsequently withdrawn from circulation.

The Center of Social Welfare Policy and Law at Columbia University, funded by the Office of Economic Opportunity, published a book entitled “How to Commence Welfare Litigation in a Federal Court, Including Model Annotated Papers.” This publication is explicitly designed to assist Legal Services attorneys who wish to commence welfare litigation against the Government.

In response to a question by the chairman of the committee when the Office of Economic Opportunity appeared before the committee during the 1970 hearings on the welfare bill, information was provided stating that one or more OEO legal services projects were involved in each of the major cases affecting welfare law in recent years. These decisions involved the prohibition of duration of residence requirements, voiding the man-in-the-house rules, requiring a hearing before assistance can be terminated, and prohibiting denial of welfare for refusal to name the putative father (the reply appears in part 2 of the 1970 hearings, pp. 969–970).

Committee provision.—The committee believes that in many cases the courts ruling in suits brought by legal services lawyers have misused the purposeful broadness of the Federal welfare statutes (which was intended to leave the basic control over public assistance with the States and their subdivisions) as an avenue for imposing by judicial action Federal requirements which, if imposed at all, should more properly be determined legislatively. The committee recognizes, however, that a statute which is intentionally phrased so as to leave considerable discretion to those who administer it (that is, the States) may give rise to some questions of interpretations. Accordingly, the committee bill provides a mechanism whereby it would be possible to avoid the necessity of litigation which is likely to result in the courts feeling constrained to assume legislative responsibilities. The bill would establish a prohibition against the use of Federal funds to pay, directly or indirectly the compensation or expenses of any individual who in any way participates in action relating to litigation which is designed to nullify congressional statutes or policy under the Social Security Act but would permit the Attorney General to waive this prohibition 60 days after he has provided the Finance Committee and the Ways and Means Committee with notice of his intent to make such a waiver.

This will give the committees time to consider the issues being raised

in the proposed litigation. If the committees determine that the intent of the statute is, in fact, open to question, they would be able to put this properly legislative question before the Congress with their recommendations for its solution and thus avoid the need for further litigation. On the other hand, if the committees determine that the suit does not involve a question of legislative intent or that the statute already clearly expresses that intent, the matter could be left to the courts.

The committees' action is in no way intended to affect the duties of legal services lawyers in connection with legal representation that involves assisting poor individuals with day-to-day problems in such areas as support payments, landlord-tenant relations, consumer issues, or even arbitrary actions of local welfare departments.

Appointment and Confirmation of Administrator of Social and Rehabilitation Services

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities at present are broad, encompassing the Federal social service programs, welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge and growing; the bulk of the \$14-billion 1972 budget for the agency is spent on the public assistance and medicaid programs.

Committee provision.—Since the conduct of this office has such a profound effect on the expenditure of vast sums of public funds, the committee bill would require Presidential appointment and Senate confirmation.

2. CHILD WELFARE SERVICES

Grants to States

Present law

Under present law, grants are made to States for child welfare services (including foster care, adoption services, and protective services for children). In 1967 the authorization for Federal grants for child welfare services was raised to \$110 million; however, the appropriation for child welfare services has remained at \$46 million since 1967.

A variety of services for children and their parents are provided by child welfare agencies through the Federal grants for child welfare services. Child welfare agencies have developed services to help children before and after trouble occurs and have worked to develop community resources that will supplement or substitute for, (1) parental care and supervision for the purpose of preventing, remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children; (2) protecting and caring for homeless, dependent, or neglected children; (3) protecting and promoting the welfare of children of working mothers; and (4) otherwise protecting and promoting the welfare of children, such as strengthening their own homes where possible or, where needed, the provision of adequate care of children away from their homes.

Child welfare services are not limited to the poor but are available to all children who need them.

Major child welfare services include the following:

1. Foster care in foster family homes or institutions when children must be removed from their own homes.
2. Emergency care and protection of children reported to be abused, neglected, abandoned or exploited by parents or guardians.
3. Services and assistance for unmarried mothers and their babies including education and training of the mothers and family planning services.
4. Homemaker services for care of children in their own home or in a foster home during the absence or incapacity of parents or to help parents improve inadequate child care and household practices to keep a family intact.
5. Counseling children and their parents in relation to behavior problems, parent-child conflicts, physical and mental handicaps and emotional and social adjustment.
6. Recruitment and licensing of child care facilities to assure adequacy of care of children and to prevent their exploitation or neglect.
7. Day care services to protect children whose mothers are temporarily absent from the home and for children who need day care for such reasons as training to compensate for a physical or mental handicap.
8. Adoption placement services to provide a permanent family home for children who have lost their parents or whose parents' rights to them have been legally terminated.

Both child welfare services and social services under Aid to Families with Dependent Children must be administered through a single organizational unit at the State or local level. However, child welfare services funds are available for providing services to many children who need them but who are not eligible to receive services under the AFDC program.

House Bill

H.R. 1 as it passed the House would retain the child welfare services program under present law but would include a separate authorization for grants to States for foster care and adoption services, beginning with \$150 million in fiscal year 1972 and rising to \$220 million in 1976 and thereafter. Payments for foster care would include payments for medical care not otherwise available, and adoption service are defined in the bill to include payments to adoptive parents to provide them with assistance in meeting the medical or remedial needs of a child who is hard to place because of a physical or mental handicap.

Committee Provision

The committee recognizes that foster care represents the largest single child welfare expenditure on the county level; foster care expenditures by counties now amount to about \$350 million, with the Federal Government paying about 8 percent of the total. But while foster family care is less expensive than institutionalizing a child that has no suitable home, providing services to keep a family together is even less expensive than foster care.

In a recent study published by the Child Welfare League, David Fanshel and Eugene B. Shinn found the cost of foster care to be very high in New York City. They were particularly critical of the fact that in New York funds were more readily available for foster care than for services to help keep families from breaking up, even when it was obvious that foster care would be far more expensive. Finding that "too many children slip into long-term foster care careers and their status becomes frozen through default rather than through a consciously arrived decision that alternatives to placement are not feasible," Fanshel and Shinn recommend that cases be screened in order to identify the ones in which foster care may be avoided through preventive services. If services can be provided to help the family to stay together, substantial savings in public funds will result.

Accordingly, the committee bill would increase the authorization for child welfare services in lieu of authorizing a separate grant earmarked for foster care and adoption services. Under the committee bill, \$200 million would be authorized for child welfare services in fiscal year 1973 (\$154 million more than the amount included in the President's 1973 budget for child welfare services), an increase of about the same amount as included for foster care and adoptions under the House-passed bill. The authorization would increase to \$215 million in fiscal year 1974, \$230 million for fiscal year 1975, \$250 million for fiscal year 1976, and \$270 million for fiscal year 1977 and thereafter.

While the committee anticipates that the bulk of the additional funds will be used to pay for foster care, the committee feels that an important advantage of not earmarking amounts specifically for foster care is that States and counties can use the child welfare services grant money to expand preventive child welfare services with the aim of avoiding the need for foster care wherever possible.

The committee urges States to eliminate any barriers hampering the provision of protective services to keep families together, and to make greater efforts to work with families wherever appropriate in order to prevent the need for placing children in foster care.

Increases in child welfare services funds under the committee bill would also make additional funds available for adoption services. The House bill attempts to encourage the adoption of hard-to-place children by authorizing payments to adoptive parents to meet the cost of remedial care for physically and mentally handicapped children if the parents are unable to do so.

Physically and mentally handicapped children, however, represent a small portion of hard-to-place children. Funds for subsidized adoptions are primarily needed in order to make adoption possible for minority group children.

Provision of subsidies would make adoption possible for children who otherwise would remain in tax-supported foster care until they reach adulthood. Many prospective adoptive parents who could provide good permanent homes for these children cannot afford to do so unless some financial aid is available for child support. These children, therefore, lack the security of a permanent family and must remain in foster care during their entire childhood. Moreover, subsidized adoption would benefit the taxpayers as well as the children since the costs of subsidizing an adoptive child are much less than maintaining the

child in foster care. States could save the administrative costs of foster care as well as some of the cost of foster payments.

The committee bill, by increasing child welfare services funding, would not limit the use of adoption service funds to physically and mentally handicapped children. Placement would also be aided under the National Adoption Information Exchange System described below.

National Adoption Information Exchange System

In addition to the increased funds for child welfare services, the committee bill would authorize \$1 million for a Federal program to help find adoptive homes for hard-to-place children. The amendment would authorize the Secretary of HEW to "provide information, utilizing computers and modern data processing methods, through a national adoption information exchange system, to assist in the placement of children awaiting adoption and in the location of children for persons who wish to adopt children, including cooperative efforts with any similar programs operated by or within foreign countries, and such other related activities as would further or facilitate adoption."

This program is patterned after the Adoption Resource Exchange of North America (ARENA), which was established by the Child Welfare League of America in 1967. Its purpose is to bring together for adoption those children for whom public and private adoption agencies in the United States and Canada can find no adoptive families, and families for whom agencies have no children. A particular objective of ARENA has been to find more homes for children of minority groups, mixed racial background, and children with physical or psychological handicaps. Agencies register children who are waiting to be adopted, and families who are waiting to receive a child. Thus, ARENA makes the adoption agencies of North America a part of a large network of adoption resources. This effort helps to overcome uneven availability of homeless children and suitable adoptive families.

The committee amendment is aimed at making the program more effective by providing for the utilization of computers and modern data processing methods. Such a computerized system would encourage and make possible many more registrations of children and families than is presently possible.

3. OTHER PROVISIONS

Demonstration Projects To Reduce Dependency on Welfare

Present law.—The Social Security Act (sections 1110 and 1115) currently authorizes appropriations for research and demonstration projects in the area of public assistance and social services. Authority under these sections has been used to fund several guaranteed minimum income experiments and also a large number of projects related to providing social services to welfare recipients.

Committee provision.—In order to place emphasis under these programs on helping persons to become economically independent, the committee bill would require that one-half of the funds spent under

these two sections be spent on projects relating to the prevention and reduction of dependency on welfare.

Quality of Work Performed by Welfare Personnel

Under present law, each State selects its own welfare personnel—trains them as it sees fit, and administers the welfare program under its own rules of conduct. There is apparently little effort to encourage any uniformity of standards of performance for welfare workers either between the States or within a State. Thus, situations have been called to the committee's attention where some welfare workers perform their duties in a very oppressive manner while others consider their principal function to simply involve the disbursement of as much public money to their "clients" as possible with little or no regard for the needs of the recipient for counseling and guidance. In many instances counseling and guidance may be far more helpful than money in rehabilitating a welfare family. Instinctively, welfare recipients become defensive and resist the former type of workers and the latter type offers them little hope of escape from the welfare cycle. Neither type is an asset to the system.

In an effort to try to upgrade the quality of work performed by welfare personnel, the committee is directing the Secretary of the Department of Health, Education, and Welfare to study and report to the Congress by January 1, 1974, on ways of enhancing the quality of welfare work, whether by fixing standards of performance or otherwise. In making this study, the Secretary could draw on the knowledge and expertise of persons talented in the field of welfare administration, including those having direct contact with recipients, and he should also benefit from suggestions made by recipients themselves as to how the level of performance in the administration of the welfare system might be improved, with a view toward ending the wide variations in employee conduct which characterize today's system, and moderating the extremes to which some social workers go in performing their duties.

Offenses by Welfare Employees

Under present Federal law there is no provision particularly directed to the question of employee conduct in the administration of the welfare program. On the other hand, the Internal Revenue Code (sec. 7214) has long contained a list of offenses the commission of any of which, by a tax employee, would bring into effect discharge from employment and penalties of (a) fines not to exceed \$10,000, or (b) imprisonment for not more than five years, or both. This law has contributed to the high quality of performance of Internal Revenue employees and has been a factor in assuring relatively uniform standards of conduct.

Committee provision.—Under the committee bill similar rules would apply under the welfare laws. Specifically, under the committee bill it would be a crime punishable by a fine of up to \$10,000 or imprisonment of up to five years, or both, in the case of a welfare employee who is found guilty of:

- (1) extortion or willful oppression under color of law; or

(2) knowingly allowing the disbursement of greater sums than are authorized by law, or receiving any fee, compensation, or reward, except as prescribed, for the performance of any duty; or

(3) failing to perform any of the duties of his office or employment with intent to defeat the application of any provision of the welfare statute; or

(4) conspiring or colluding with any other person to defraud the United States or any local, county or State government; or

(5) knowingly making opportunity for any person to defraud the United States; or

(6) doing or omitting to do any act with intent to enable any other person to defraud the United States or any local, county or State government; or

(7) making or signing any fraudulent entry in any book, or making or signing any application, form or statement, knowing it to be fraudulent; or

(8) having knowledge or information of the violation of any provision of the welfare statute which constitutes fraud against the welfare system, and failing to report such knowledge or information to the appropriate official; or

(9) demanding, or accepting, or attempting to collect, directly or indirectly as payment or gift, or otherwise, any sum of money or other thing of value for the compromise, adjustment, or settlement of any charge or complaint for any violation or alleged violation of law, except as expressly authorized by law.

In addition to these penalties the employee involved shall be dismissed from office or discharged from employment.

Evaluation of Programs Under the Social Security Act

The Department of Health, Education, and Welfare has frequently contracted with outside firms and organizations to evaluate programs under the Social Security Act. A list of some of the evaluations carried out in 1971 appears on table 1.

The evaluations involve millions of dollars, and are of uneven quality. In addition, since the firm doing the evaluating is dependent on the Federal agency for funds, it is rarely critical of the agency or the program which is the source of its funds.

Committee provision.—The committee bill includes a provision assigning to the General Accounting Office the basic role of evaluating programs under the Social Security Act. In addition, the amendment would not permit any Federal agency to enter into a contract to evaluate any program under the Social Security Act (if an expenditure of more than \$25,000 is involved) unless the Comptroller General approves the study in advance. His approval would be conditioned on his determination that:

(a) The conduct of such study or evaluation of such program is justified;

(b) The department or agency cannot effectively conduct the study or evaluation through utilization of regular full-time employees; and

(c) The study or evaluation will not be duplicative of any study or evaluation which is being conducted, or will be conducted within the next twelve months, by the General Accounting Office.

TABLE 1.—EXAMPLES OF EVALUATIONS OF PROGRAMS UNDER THE SOCIAL SECURITY ACT BEING CONDUCTED IN 1971

Project title	Grantee	Project period	Total funds	Social Security Act titles
<i>Social Security Administration Studies</i>				
1. Evaluation of Incentive Reimbursement Experiment Conducted by the Commission for Administrative Services in Hospitals (Southern California Blue Cross).	Hospital Research and Education Trust and the University of California.	June 1, 1970–July 1, 1973.	\$169,069	XVIII.
2. Evaluation of the Incentive Reimbursement Experiment Conducted by the Connecticut Hospital Association.	Yale University.....	July 1, 1969–Apr. 30, 1973.	77,473	XVIII.
3. Evaluation of Incentive Reimbursement Experiment Conducted by the Insurance Plan of Greater New York.	Harvard College.....	Jan. 1, 1970–Dec. 31, 1973.	458,104	XVIII.

*Health Services and Mental
Health Administration Studies*

4. An Assessment of Child Health Care Delivery and Organization.	Minnesota Systems Research, Inc.	July 1, 1966– Undetermined.	1,415,082	V.
5. Evaluation Studies on Maternal and Infant Care Projects.	University of Maryland, Baltimore.	June 1, 1961–June 30, 1973.	1,218,719	V.
6. Influence of Medi-Cal on Outcome of Delivery.	Edwin H. Jackson.....	Jan. 1, 1970–June 30, 1972.	59,752	XIX.
7. Systems Analysis of Pediatrician Efficiency.	Robert E. Cooke, Neil H. Sims.	July 1, 1967–June 30, 1972.	857,962	V.
8. Evaluation of Infant Group Care in New York City.	Mark Golden.....	Feb. 1, 1971–Dec. 31, 1976.	500,000	V.
9. Evaluation of Health Services for Foster Children.	Florence Kavalier.....	May 1, 1971–Apr. 30, 1974.	300,000	IVB, V.

*Social and Rehabilitation Service
Studies*

10. "HEW Day Care Center"	Thiokol Chemical Corp. ...	June 1, 1970–June 30, 1973.	165,000	IVB.
11. "A Monitoring System for Family and Child Care Services."	University of Georgia.....	June 30, 1969–June 30, 1973.	543,000	IVA, B.
12. Evaluation of Quality Control in Public Assistance.	Westad, Inc.....	June 1970–October 1971.	103,500	I, IV, X, XIV, XVI.

TABLE 1.—EXAMPLES OF EVALUATIONS OF PROGRAMS UNDER THE SOCIAL SECURITY ACT BEING CONDUCTED IN 1971—Continued

Project title	Grantee	Project period	Total funds	Social Security Act titles
13. Earnings Exemption Incentive Study.	National Analysts.....	April 1969–April 1971..	261,600	I, IV, X, XIV, XVI.
14. Evaluation of the Social Work Education Program (Sec. 707).	Datagraphics, Inc.....	April 1970–February 1971.	95,562	VII.
15. Medicaid Utilization Reporting System.	Scientific Resources.....	June 1970–March 1971.	199,400	XIX.
16. Design of an Information and Display System for Evaluating Child Care Services.	AVCO.....	June 1971–June 1972..	147,373	IVA, B.
17. Social Services Effectiveness Study.	Booz-Allen.....	June 1971–June 1972..	213,000	I, IV, X, XIV, XVI.
18. Compliance Monitoring System for Social Service Programs.	University of Georgia.....	June 1971–September 1972.	300,000	I, IV, X, XIV, XVI.
19. Cost Analyses of Social Services.	Touche-Ross.....	June 1971–May 1972...	243,000	I, IV, X, XIV, XVI.
20. Pretest of Government Social Services.	State of Virginia, Human Resources Planning.	June 1970–June 1971	50,000	I, IV, X, XIV, XVI.
21. Purchase of Social Services by States.	Booz-Allen.....	June 1970–June 1971..	51,100	I, IV, X, XIV, XVI.

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22. Study of Community Development Activity in the Social Service System.	National Association for Community Development.	June 1970-June 1971..	50,000	I, IV, X, XIV, XVI.
23. Study of Cost and Output of Graduate Social Work Education and An Exploratory Study for the Deans' Committee of the Western Interstate Commission on Higher Education.	Cooper & Co.....	May 8, 1969-Nov. 20, 1970.	105,086	VII.
24. Study of Organizational Climate and Structure on Social and Rehabilitation Workers and Work Performance.	Manpower Science Services, Inc.	June 30, 1970-Apr. 30, 1972.	78,917	VII.
25. Assessment of Title VII, Section 707 Program.	Synetics Corp.....	May 1, 1970-Apr. 30, 1972.	105,385	VII.
26. Earnings Exemption Study...	National Analysts, Inc....	Apr. 16, 1969-Oct. 31, 1971.	379,600	I, IV, X, XIV, XVI.
27. DSSH-Kaiser Health Plan Evaluation Project.	Department of Social Services and Housing, Honolulu.	July 1, 1971-Dec. 31, 1972.	144,511	XIX.

TABLE 1.—EXAMPLES OF EVALUATIONS OF PROGRAMS UNDER THE SOCIAL SECURITY ACT BEING CONDUCTED IN 1971—Continued

Project title	Grantee	Project period	Total funds	Social Security Act titles
<i>Department of Labor Studies</i>				
28. Supportive Services in Four Manpower Programs.	Camil Association.....	June 1971–July 1972...	178,000	IVC.
29. Longitudinal Study in WIN...	Auerbach.....	July 1969–July 1972....	1,500,000	IVC.
30. The Development of Guidelines for Referral of AFDC Recipients to WIN and Related Manpower Programs.	Institute for Interdisciplinary Studies.	June 1969–June 1972..	691,000	IVC.

X. CHILD SUPPORT

Child Support

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X. CHILD SUPPORT

The approach of the committee bill in dealing with the problem of mounting dependency on Aid to Families with Dependent Children involves the establishment of a new employment program, with strong work incentives, for families headed by an employable adult, and it involves bringing the remaining AFDC program under legislative and administrative control.

There is a third and equally important element in the committee approach, one which deals with the reasons most AFDC recipients are on the welfare rolls: the failure of the father to support his children, whether or not born out of wedlock.

The committee believes that all children have the right to receive support from their fathers. The committee bill is designed to help children attain this right, including the right to have their fathers identified so that support can be obtained. The immediate result will be a lower welfare cost to the taxpayer, but more importantly, as an effective support collection system is established fathers will be deterred from deserting their families to welfare and children will be spared the effects of family breakup.

The Problem

Aid to Families with Dependent Children (AFDC) offers welfare payments to families in which the father is dead, absent, disabled, or, at the State's option, unemployed. When the AFDC program was first enacted in the 1930's, death of the father was the major basis for eligibility. With the subsequent enactment of survivor benefits under the social security program, however, the portion of the caseload eligible because of the father's death has grown proportionately smaller, from 42 percent in 1940 to 7.7 percent in 1961 and 4.3 percent in 1971. The percentage of AFDC families in which the father is disabled has diminished from 18.1 percent in 1961 to 9.8 percent in 1971.

Absent fathers.—It is in those families in which the father is "absent from the home" that the most substantial growth has occurred. As a percentage of the total caseload, AFDC families in which the father was absent from the home increased from 66.7 percent in 1961 to 74.2 percent in 1967, 75.4 percent in 1969, and to 76.2 percent in 1971.

In terms of numbers of recipients rather than percentages, 2.4 million persons were receiving AFDC in 1961 because the father was absent from the home. By 1967, that figure had grown to 3.9 million and by 1969 to 5.5 million. By the beginning of 1971, 7.5 million persons were receiving AFDC because of the father's absence from the home, and by the end of 1971 that figure had grown to almost 8 million. Thus in the past four years, families with absent fathers have contributed more than 4 million additional recipients to the AFDC rolls.

Broken homes.—What kinds of families are these in which the father is absent from the home? Basically, they represent situations in which the marriage has broken up or in which the father never married the mother in the first place. In 45.2 percent of the AFDC families on the rolls in the beginning of 1971, the father was either divorced or legally separated from the mother, separated without court decree, or he had deserted the family. In 15.2 percent of the families receiving AFDC at the beginning of 1971, the father had deserted. Applying that percentage to the caseload today, this means that well over 1½ million welfare recipients are getting AFDC because the father has deserted.

Illegitimacy.—The largest single cause of AFDC eligibility is illegitimacy, and this has been the fastest growing category in recent years. In 21.3 percent of the families receiving AFDC in 1961, the mother was not married to the father of the child. By the beginning of 1971, this proportion had grown to 27.7 percent. Applying that percentage to the present caseload, almost 3 million AFDC recipients today are found in families where the father is not married to the mother.

Failure To Enforce Child Support

The enforcement of child support obligations is not an area of jurisprudence about which this country can be proud. Researchers for the Rand Corporation (Winston and Forsher, "Nonsupport of Legitimate Children by Affluent Fathers as a Cause of Poverty and Welfare Dependence," December 1971) cite studies that show "a large discrepancy exists between the normative law as expressed in the statutes and the law in action." Hundreds of thousands of unserved child support warrants pile up in many jurisdictions and often traffic cases have a higher priority. The blame for this situation is shared by judges, prosecutors, and welfare officials alike, and is reinforced by certain myths which have grown up about deserting fathers. The Rand researchers state:

Many lawyers and officials find child support cases boring, and are actually hostile to the concept of fathers' responsibility for children. A report to the Governor [of California] expresses concern at the "cavalier attitudes on the subject of child support expressed by some individuals whose work responsibilities put them in daily contact with persons affected by the problem." It continues, "Some of these individuals believe that child support is punitive and that public assistance programs are designed as a more acceptable alternative to the enforcement of parental responsibility." The same phenomenon appears in our interview material.

The researchers dispute the myths about absent fathers that inhibit enforcement of support obligations:

[The fathers] have not disappeared. Usually they were living in the same county as their children. They are not supporting many other children. Ninety-two percent of the nonsupporting fathers had a total of three or fewer children.

Only 13 percent were married to other women, with another 1 percent each divorced or separated from another or of unknown marital status. The nonwelfare fathers were more likely

to have remarried; the welfare fathers were more likely to be still married to the "complaining witness."

The amount of child support awarded was not unreasonably large. For those nonsupporting fathers who were already under court order to contribute to their children's support, the typical payment ordered was \$50 a month. In 33 percent of the non-welfare cases, the order called for \$50 or less.

The Rand Corporation researchers emphasize the number of well-off physicians and attorneys whose families ultimately are forced onto welfare because of insufficient mechanisms for enforcement of obligations to support. This situation, they point out, is confirmed by investigators, who point to the difficulty of proving the income of the self-employed, the ease with which unwilling fathers can conceal their assets, the statutory barrier to collecting from military personnel and Federal employees, and the low priority given child support investigations by the understaffed district attorneys' offices.

The Rand researchers further point out that although there is a lack of definitive statistics on the number of affluent fathers whose families are on welfare, census figures on poverty and AFDC caseloads are consistent with the hypothesis that much middle-class poverty is caused by fathers' nonsupport:

From 1959 to 1968, while the proportion of all families in poverty declined from 20 to 10 percent, and the rate for male-headed families went down to 7 percent, poverty among female-headed families increased to 32 percent. In 1970 it reached 36 percent, and 18 percent of college-educated female heads of families were poor—the corresponding figure for males is 3 percent.

During the years 1961 to 1968, middle-class women appeared on the AFDC rolls in large enough numbers to raise the average educational and occupational level of recipients. They become eligible for aid when prevented from working by serious problems—and they somehow managed, while still eligible, to go off the rolls at twice their proportion in the active caseload. How many went on welfare to obtain enforcement of child support orders?

Present Law

The committee has long been aware of the impact of deserting fathers on the rapid and uncontrolled growth of families on AFDC. As early as 1950, the Congress provided for the prompt notice to law enforcement officials of the furnishing of AFDC with respect to a child that had been deserted or abandoned. In 1967, the committee instituted what it believed would be an effective program of enforcement of child support and determination of paternity. The 1967 Social Security Amendments require that the State welfare agency establish a separate, identified unit whose purpose is to undertake to establish the paternity of each child receiving welfare who was born out of wedlock, and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for the child from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to

both Social Security and (if there is a court order) to Internal Revenue Service records in locating deserting parents. The effectiveness of the provisions of present law has varied widely among the States.

In its March 13, 1972, study of current child support programs in four States, the General Accounting Office noted that the Department of Health, Education, and Welfare

has not monitored the States' child support enforcement activities and had not required the States to report on the status or progress of the activities. Consequently, HEW regional offices did not have information on the number of absent parents or amount of child support collections involved or the progress and problems being experienced by the States in collecting child support. Also, HEW regional officials have not emphasized child support collection activities within the total welfare program. . . . According to regional officials HEW has not emphasized the collection of child support payments because of a shortage of regional staff and because this activity represents a small segment of the total effort needed to administer the AFDC program. Regional officials informed us that they did not, at the time of our fieldwork, have any plans to evaluate the support enforcement programs or impose reporting requirements on the States.

Experience of the State of Washington in Collecting Child Support

Against this background of lack of leadership by the Department of Health, Education, and Welfare, the General Accounting Office singled out the State of Washington as being considerably more successful in locating deserting fathers and in collecting child support payments than the other three States reviewed. The General Accounting Office report concluded that Washington's success resulted from these four features of its child support enforcement program:

Special unit.—The State has established a separate administrative unit (the Collections Section) which is operated on a State-wide basis much like a bill collection agency. The Collections Section, which is responsible for locating absent parents and collecting child support, is set up to quickly locate absent parents and encourage them to begin regular support payments. The section's procedures also provide for monitoring absent parents' payment records and following up promptly when payments become delinquent.

Encouraging voluntary payments.—Emphasis is placed on encouraging absent parents to contribute child support voluntarily; legal actions or threatening legal action is used only as a last resort. Prompt personal contacts are made by Collections Section personnel with the parents of newly enrolled AFDC children to obtain voluntary support payments based on the parent's ability to pay (regardless of the existence of any court orders or amounts specified by court orders). Regarding the use of legal action, the State's philosophy is that to obtain child support the State must compete successfully for the limited funds of the absent parent. Washington State believes that legal action or even the threat of legal action might cause the absent parent to relocate to avoid prosecution or discourage him from making voluntary contributions within his means.

No caseworker involvement.—Caseworkers do not become involved in and have no responsibility for collection activities. Time spent by caseworkers to locate and collect child support from absent parents means less time for providing services, which is a caseworker's primary interest and concern. A person other than a caseworker who is properly trained to carry out location and collections activities and who can devote full-time to these activities can be more effective in achieving collections.

Legal debt of deserting father.—By State law, AFDC assistance payments made to or on behalf of dependent children constitute a debt payable to the State by the absent parent or person legally liable for support of the children. Although the State of Washington had common law remedies for obtaining child support it was of the opinion that these remedies were not effective. Therefore, the State enacted specific legislation to supplement its existing common law remedies.

Committee Bill

In view of the fact that most States have not implemented the provisions of present law relating to the enforcement of child support and establishment of paternity in a meaningful way, the committee believes that new and stronger legislative action is required in this area which will create a mechanism to require compliance with the law. The major elements of this proposal have been adapted from those States which have been the most successful in establishing effective programs of child support and establishment of paternity.

Some of the provisions of the committee bill will be available to deserted families generally, regardless of welfare status. It is hoped that making these provisions available to all deserted families will help to prevent further expansion of the welfare rolls.

ASSIGNMENT OF RIGHTS TO COLLECTION OF SUPPORT PAYMENTS

The committee believes that the most effective and systematic method for an AFDC family to obtain child support from a deserting parent is the assignment of the family support rights to the government for collection. The committee bill requires that a mother, as a condition of eligibility for welfare, assign her right to support payments to the government and requires her to cooperate in identifying and locating the father, in securing support payments, and in obtaining any money or property due the family. The assignment of support rights will continue as long as the family continues to receive assistance. When the family goes off the welfare rolls, the deserting parent will continue for a three-month period to make payments to the government collection agency (which will pay the money over to the family at no cost to them). This period will allow the collection agency time to notify the father that he will be making support payments in the future directly to the family, and to take any other necessary administrative actions.

If by the end of the three-month period the father has met his support obligation for at least 24 consecutive months, he will begin making payments directly to the family which no longer receives welfare. But if he has not yet demonstrated his reliability by making support

payments for 24 consecutive months, the mother would have the election of continuing to assign her rights and to utilize the governmental mechanisms for collecting support for an additional period until the father has met his support obligations for 24 consecutive months. If she does so elect, the cost of collection will be deducted from the amount collected and the net balance will be sent to the mother.

The assignment of family support rights would initially be to the Federal Government. However, the Attorney General is directed to study the support programs in the various States, consult with State and local law enforcement officials and knowledgeable private experts in the field, and to derive and apply an objective set of criteria to evaluate the effectiveness of State programs of child support and determination of paternity. He would delegate the support rights which have been assigned to him to those States which he finds to have efficient and effective programs of establishing paternity and enforcing child support. However, a residual obligation to the United States based on welfare payments to the family would continue to lie against the absent parent and be enforceable by the Attorney General.

The Attorney General would also be authorized to delegate the assignment of family support rights to political subdivisions of the State that have effective programs, even though the State as a whole does not. Thus if a State does not have an effective program, the Attorney General might contract with those local jurisdictions which do have effective programs and he will directly operate the program in the rest of the State.

If the Attorney General retains the assigned support rights, they could be enforced by Federal attorneys in either State or Federal courts. The committee bill would provide that OEO lawyers would be made available to assist Justice Department attorneys in carrying out their responsibility.

The Attorney General, whether acting on his own behalf or at the request of a State or local subdivision, may make certification to the Secretary of the Treasury for collection by the Internal Revenue Service of the amount of the obligation owed.

Since the support obligations are not a tax and will change periodically in amount, the statutes of limitations on the collections of taxes assessed would be tolled by recertifications of the amount of the support obligation owed. For administrative reasons, the amount owed by a specific individual could not be certified more often than quarterly.

Where the Federal Government retains the assigned support rights, the full amount of moneys collected would be retained by the Federal Government after the current needs of the family (as determined under a court order or a voluntary agreement) have been met. Moreover, Federal AFDC payments to the State would be reduced by the amount these collections of support decrease the State's welfare costs. This constitutes one of the incentives for the development of effective State programs; others are discussed below.

The House bill provided that the Federal share for State expenses for establishing paternity, locating absent parents, and securing support would be increased from 50 to 75 percent. The committee bill adopts this approach, but with a proviso that there be no Federal participation in State programs which do not meet the Attorney Gen-

eral's standards of effectiveness. Under this provision 75 percent matching will apply to expenditures under the State or local support programs which will be composed of the following elements of existing law (some of them modified) plus such other elements which the Attorney General finds necessary for efficient and effective administration: (a) Determination of paternity and securing support through a separate organizational unit (sec. 402(a) (17) of existing law); (b) cooperative arrangements with appropriate courts and law enforcement officials (sec. 402(a) (18) of existing law); (c) location of deserting parents including use of records of Federal agencies (sec. 402(a) (21) of existing law); (d) the location and enforcement of support orders from other States against the deserting parent (sec. 402(a) (22) of existing law).

The Attorney General will replace the Secretary of Health, Education, and Welfare in supervising the administration of these programs.

It should be noted that the provision in the committee bill provides only that a separate organizational unit be established for enforcement of support obligations and does not stipulate, as does existing law, that the organizational unit be in the welfare agency. Under the committee bill, the States or subdivisions will be free to establish such a unit within or outside their welfare agencies. Under existing law, the States in administering their support collection and establishment of paternity programs are allowed to enter financial arrangements with courts and law enforcement officials in order "to assure optimum results". These financial arrangements will be subject to 75 percent Federal matching, but the committee expects the States to continue to devote to this purpose at least as much non-Federal funding as they currently provide.

The committee realizes that the January 1973 effective date means that of necessity the Attorney General will have to provisionally approve some existing support collection programs whose effectiveness has not been thoroughly studied. These studies, however, will be pursued as expeditiously as possible and determinations of effectiveness should not be unduly delayed.

LOCATING A DESERTING PARENT; ACCESS TO INFORMATION

Under the committee bill, the State or local Government would proceed to locate the absent parent, using any information available to it, such as the records of the Internal Revenue Service, the Social Security Administration and other government agencies. The committee bill extends access to these Federal records to any parent seeking support from a deserting spouse regardless of whether the family is on welfare. Non-welfare families desiring to use this means of finding the absent parent would make the necessary application at local welfare offices. These families would be charged a fee designed to cover the cost of the location service, and the Federal, State, and local costs involved in the service would be met from the fees collected.

As a further aid in location efforts, welfare information now withheld from public officials under regulations concerning confidentiality would be made available by the committee bill; this information would also be available for other official purposes. The current regulations are based on a provision in the Social Security Act which since

1939 has required State programs of Aid to Families with Dependent Children to "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of Aid to Families with Dependent Children." This provision was designed to prevent harassment of welfare recipients. The committee bill makes it clear that this requirement may not be used to prevent a court, prosecuting attorney, tax authority, law enforcement officer, legislative body or other public official from obtaining information required in connection with his official duties such as obtaining support payments or prosecuting fraud or other criminal or civil violations.

Incentives for States and localities to collect support payments.— Under present law, when a State or locality collects support payments owed by a father, the Federal Government is reimbursed for its share of the cost of welfare payments to the family of the father; the Federal share currently ranges between 50 percent and 83 percent, depending on State per capita income. In a State with 50 percent Federal matching, for example, the Federal Government is reimbursed \$50 for each \$100 collected, while in a State with 75 percent Federal matching the Federal Government is reimbursed \$75 for each \$100 collected.

Consistent with the committee's block-grant approach for AFDC, and as an incentive for the development of effective State and local programs, the committee bill provides that the entire amount of welfare payments from support collections collected by the State would remain with the State. If, however, the actual collection and determination of paternity mechanism is carried out by local authority, the State would pay the local authority 25 percent of 12 months' worth of welfare payments (not taking into account the \$20 disregard allowed the family) or, if less, 25 percent of the amount collected relating to a 12-month period. For example, assume a family receives \$160 monthly in AFDC. If the father begins contributing \$100 per month, the local authority which obtained the collection would receive \$300 (25 percent of \$100 is \$25; 12 times \$25 equals \$300). If the father begins contributing \$200 per month, the local authority would receive \$480 (25 percent of the \$160 AFDC payment is \$40; 12 times \$40 equals \$480). Both of these examples assume the local authority actually collects the required support payment for at least 12 months.

In the situation where the location of runaway parents and the enforcement of support orders is carried out by a State other than that in which the deserted family resides, the State or local authority which actually carries out the location and enforcement functions will be paid the 25 percent bonus.

The committee bill provides that the Attorney General would have to be reimbursed for any Federal costs (other than for blood typing tests) incurred to aid the States and localities in their support collection and determination of paternity efforts. These costs will, however, be subject to 75 percent Federal matching if carried out under programs which meet the Attorney General's standards of effectiveness.

Voluntary approach.—The committee expects that most States will find it desirable to encourage absent parents to enter voluntarily into an arrangement for making regular support payments; legal action

would be used to the extent that a State feels the voluntary method has proven or is likely to prove unsuccessful. The use of the voluntary approach can avoid the need for court action and formal collection procedures. The record of the State of Washington in collecting support payments voluntarily was highlighted in a recent study by the General Accounting Office as a key element in their support collection program; the committee hopes that the experience of Washington State can serve as a model for all States.

Under the committee bill, voluntary agreements may be made—

- (1) If there is no court order, or
- (2) If there is a court order that can not reasonably be expected to be enforced or collected.

Any voluntary agreement must provide that support payments will not cease if the family goes off the rolls. If a State utilizes voluntary agreements, it must provide an administrative mechanism for the enforcement of the agreements. As with other contractual arrangements, the State or the absent parent can resort to judicial process to change the agreement if they feel that it no longer is consistent with their interests. But as long as the agreement remains in effect, it will be enforceable by appropriate State administrative process.

Civil action to obtain support payments.—Where the voluntary approach is not successful, the States can enforce the assigned support rights through applicable judicial and administrative processes. The States, as agents of the Federal Government, would be able to utilize, through the Attorney General, all the enforcement and collection mechanisms available to the Federal Government, including the use of the Internal Revenue Service collection procedures. However, States must be diligent in enforcing support rights and they will have to make reasonable efforts in utilizing their own collection mechanisms before the use of the Federal collection facilities would be authorized. If these mechanisms are utilized the Federal Government would have to be reimbursed on a cost basis.

DISTRIBUTION OF COLLECTIONS

The first \$20 of any support collected in a month will be disregarded and the remainder will be used to offset or reduce the AFDC payment to the family for the month. If the support payment is sufficient to entirely offset the family's AFDC eligibility for the month, the entire support payment up to the amount of the family's support needs under a court order or voluntary agreement will go to the family and any excess will be returned to the State as a reimbursement for past welfare payments.

For example, where a family is getting \$200 per month in AFDC and a support order for \$250 has been obtained on their behalf, any support payment collected by the State would be distributed as follows:

1. If a support payment of \$100 is made for a month, only \$80 would be used to reduce or offset the \$200 AFDC payment since \$20 of the support payment must be disregarded for welfare purposes. Thus the total income of the family would be \$220.
2. If a support payment of \$225 is made, all \$225 is turned over to the family, which would no longer be on the welfare rolls.

3. If a support payment of \$275 is made, the first \$250 would be paid to the family (the amount specified in the support order); and the remaining \$25 would be retained by the State to repay it for assistance provided to the family in the past. The family would no longer be on the welfare rolls.

A somewhat different distribution of funds is provided where the collection is made by the Attorney General or a political subdivision acting as his delegate rather than by the State. The amounts shown in the above example as being retained by the States for past welfare payments would be retained by the Federal Government (or by the political subdivision acting as delegate to the extent it participates in the cost of the AFDC payment). In addition, an amount equal to the State's saving would be deducted from the Federal AFDC grant to the State. The end result with respect to the income to the family would, however, be the same.

RESIDUAL OBLIGATION TO FEDERAL GOVERNMENT

Under the committee bill, past and continuing welfare payments would serve as a residual monetary obligation of the absent parent to the United States. The obligation would generally be the cumulative amount derived from monthly amounts which would be based on the lesser of the welfare assistance paid the family, or 50 percent of the absent spouses' income (but not less than \$50 a month). The obligation would accrue interest at a rate of 6%. The committee bill would limit the accumulation of further obligations when the absent parent makes support payments. However, support payments collected by the States would not be used to discharge the obligation to the Federal Government in lieu of reducing welfare payments or terminating eligibility altogether. Moreover, regardless of whether the State or the Attorney General enforces the assigned support rights, meeting the continuing support needs of the family (as determined under a court order or voluntary agreement) would have a priority over the discharge of the residual obligation to the Federal Government. If the father's monthly support payments exceed the amount needed to eliminate the welfare payment the family had been receiving, the excess would be paid to the family (up to the amount of the family's support needs). Amounts in excess of the family's monthly support needs would be retained by the State or by the Federal Government as described earlier. In either case, all monthly payments in excess of the welfare payment would reduce his obligation to the Federal Government.

For example, a father who has been ordered to pay his family \$250 per month may have a \$1,000 residual obligation to the Federal Government because AFDC payments of \$100 per month were provided to his family for 10 months while he was not making support payments. If in the next month a \$300 support payment is collected from him by the State, the family gets the first \$250, removing it from the welfare rolls, and the remaining \$50 is retained by the State to reimburse it for past AFDC payments. The father's residual obligation is reduced by \$200 the amount by which his payment exceeds the AFDC payment.

All or part of the obligation to the Federal Government might be suspended or forgiven by the Attorney General upon a finding of good cause.

CRIMINAL ACTION

The committee bill provides Federal criminal penalties for an absent parent who has not fulfilled his obligation to support his family and the family receives welfare payments in which the Federal Government participates. His obligation to support would be determined by applying State civil and/or criminal law. In some cases this obligation may be determined under a voluntary agreement, and an absent father contributing to the support of his family in this manner would be meeting the support requirements. The sanctions for failure to support could include a penalty of 50 percent of the amount owed or a fine of up to \$1,000 or imprisonment for up to one year or a combination of these.

The Federal criminal statute created by the committee bill would not be exclusive, and State civil or criminal laws concerning non-support could be applied. In brief, this provision of the committee bill represents an additional remedy rather than a replacement of existing State remedies.

DETERMINING PATERNITY

The committee is concerned at the extent to which the dependency on AFDC is a result of the increasing number of children on the rolls who were born out of wedlock and for whom parental support is not being provided because the identity of the father has not been determined. The committee believes that an AFDC child has a right to have its paternity ascertained in a fair and efficient manner. Although this may in some cases conflict with what a social worker may consider the mother's short-term interests, the committee feels that the child's right to support, inheritance, and to know who his father is deserves the higher social priority. In 1967, Congress enacted legislation requiring the States to establish programs to determine the paternity of AFDC children born out of wedlock so that support could be sought. The effectiveness of this provision was greatly curtailed both by the failure of the Department of Health, Education, and Welfare to exercise any leadership role and also by court interpretations of Federal law in decisions which prevented State welfare agencies from requiring that a mother cooperate in identifying the father of a child born out of wedlock.

Current status of children born out of wedlock.—Children whose parents have never married present a serious problem of support and care. At common law such a child was a "son of nobody" and neither parent could be held responsible for it. The original laws imposing support of the child on a parent were enacted solely to prevent the community from having the child as a public charge. In many States, it is possible for the State's attorney, or the public welfare authorities, to bring an action against the man who is alleged to be the father of the child. If the mother of the child cannot afford her own attorney, she has recourse to such a procedure.

Whether the action is brought by the State's attorney or by the mother of the child, the court procedure is essentially the same. The reputed father is brought into court by a summons or by a warrant of arrest, depending upon whether the law of the State makes the action

a civil or a criminal one. There is usually a preliminary hearing before a justice of the peace, county judge, or similar officer. There may then be a trial by jury. The accused is required to give a bond as security pending the actual determination of paternity only if the judge has reason to believe that the man is the father of the child. Such actions may be brought in the county where the child was born or where the father resides. They must be brought within a certain time, usually two years, after the birth of the child.

After a man has been adjudged to be the father of an illegitimate child, he is usually expected to assist with its support and to pay the expenses of the mother's confinement. The amount of support varies according to the State statutes.

In taking the position that a child born out of wedlock has a right to have its paternity ascertained in a fair and efficient manner, the committee acknowledges that legislation must recognize the interest primarily at stake in the paternity action to be that of the child. Since the child cannot act on his own behalf in the short time after his birth when there is hope of finding its father, the committee feels a mechanism should be provided to ascertain the child's paternity whenever it seems that this would both be possible and in the child's best interest.

Cooperation of mother.—The committee bill would make cooperation in identifying the absent parent a condition for AFDC eligibility. As a further incentive for cooperation, the first \$20 a month in support collections for a family would be disregarded (effective January 1, 1973) for purposes of determining the amount of welfare payments to the family. Thus, the family would always be better off if support payments are made by the absent parent.

Blood grouping laboratories.—The committee is convinced that despite widely held beliefs to the contrary, paternity can be ascertained with reasonable assurance, particularly through the use of scientifically conducted blood typing. It is impressed by evidence that blood typing techniques have developed to such an extent that they may be used to establish evidence of paternity at a level of probability wholly acceptable for legal determinations.

In a book entitled *Illegitimacy: Law and Social Policy*, Harry D. Krause, Professor of Law at the University of Illinois, deals at great length with the value of blood typing in establishing paternity; he reports that the biological reliability of expertly performed blood tests has been estimated to be extremely high. An individual may be excluded from possibility as a father on the basis of blood tests; in addition, the probability of his being the father can also be computed quite precisely on the basis of blood typing:

. . . We may conclude that even if blood typing cannot establish paternity positively in *medical* terms, the positive proof of paternity may reach a level of probability which is entirely acceptable in *legal* terms. In other words, blood typing results should be admissible as evidence even if an exclusion is not established. They should be entitled to whatever weight the fact that an exclusion was not established in a particular case should have—and that weight should be computed by an expert in terms of statistical probabilities. To put it very simply, if the blood constellation of father, mother and child is such that only a small percentage of a

random sample of men would not be excluded as possible fathers, then it is of considerable significance that this particular man (if he has been linked with this mother by other evidence) is not excluded. That "significance," of course, falls short of the absolute certainty involved in an exclusion but, in a given case, may equal that of other types of circumstantial evidence.

Blood grouping tests must be conducted expertly in order to avoid error; but the possibility of error can be all but eliminated if appropriate and well-known medical procedures are followed by experts. Three laboratories under U.S. Army control now do blood testing for use in paternity matters. However, sufficient facilities to perform expert blood typing are not currently available to the courts. Therefore, the committee bill provides that the Department of Health, Education, and Welfare be authorized and directed to establish or arrange for regional laboratories that can perform the highly sophisticated blood typing work necessary for purposes of establishing paternity for State agencies and the courts. Thus, such tests will be readily available by having specialized blood typing laboratories meeting the highest professional standards within a few hours of air mail shipment from any part of the country. No requirement would be made in Federal law that blood tests be made mandatory. The committee notes, however, that Rule 35 of the Federal Rules of Civil Procedure provides that "when the mental or physical condition (including the blood group) of a party . . . is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician. . . ."

Under the committee bill, the services of the laboratories would be available with respect to any paternity proceeding, not just a proceeding brought by, or for, a welfare recipient. This service will be provided by the Department of Health, Education, and Welfare to courts and governmental collection agencies without cost.

Affidavit of paternity.—Finally, the committee bill provides that a father not married to the mother of his child would be required to sign an affidavit of paternity if he agreed to make support payments voluntarily in order to avoid court action. Most States do not permit initiation of paternity actions more than two or three years after the child's birth; the affidavit would serve as legal evidence of paternity in the event that court action for support should later become necessary.

LEADERSHIP ROLE OF JUSTICE DEPARTMENT

The Attorney General would have primary responsibility for the overall direction of the collection of support and determination of paternity programs as well as responsibility for the enforcement of the criminal and civil sanctions which may be applicable to runaway parents. He will assess the effectiveness of the State and local programs and based on this assessment will determine which level of government will carry out these activities. To coordinate and lead efforts to obtain child support payments, the committee bill would require each U.S. Attorney to designate an assistant who would be responsible for child support. This Assistant U.S. Attorney would assist and maintain liaison with the States in their support collection efforts and would undertake Federal action as necessary. He would also be required to

prepare for submission to Congress quarterly reports on all his activities in this area. The Attorney General would have the overall responsibility for enforcement of support rights. The bill would require the States and political subdivisions to keep full records of their collections and disbursements and to provide such other information as will enable him to evaluate the effectiveness of their programs.

The committee bill requires that records be maintained of the amounts of support collected and of the administrative expenditures incurred in the collection effort at the Federal level. The Attorney General would be required to submit an annual report to Congress concerning his activities.

FEDERAL CHILD SUPPORT FUND

The committee bill would establish a Federal Child Support Fund. All amounts collected by the Federal Government from absent parents would be deposited in the Fund. Other receipts to the Fund would include reimbursement by the States or political subdivisions for the cost of using Federal location and child support collection facilities, and fees collected from those individuals not on welfare who may use Federal location and child support collection services. The moneys in the Fund would be used for support payments to the families when these payments are made by the Federal Government, and to meet the Federal expenses of location and support collections efforts. Appropriations into this Fund would be authorized as necessary to meet any costs not otherwise covered by receipts into the Fund. The Fund would not be used for the 75 percent Federal matching of State or political subdivision expenses nor for the expenses of establishing blood typing laboratories.

ATTACHMENT OF FEDERAL WAGES

State officials have recommended that legislation be enacted permitting garnishment and attachment of Federal wages and other obligations (such as income tax refunds) where a support order or judgment exists. At the present time, the pay of Federal employees, including military personnel, is not subject to attachment for purposes of enforcing court orders, including orders for child support or alimony. The basis for this exemption is apparently a finding by the courts that the attachment procedure involves the immunity of the United States from suits to which it has not consented.

In a 1941 case (*Applegate v. Applegate*), the Federal District Court for the District of Columbia explained this position in this way:

While the Congress has seen fit to waive the immunity of the United States from suit in the case of certain money claims against it and also in case of many of the corporations created by it, it has so far never waived that immunity and permitted attachment or garnishee proceedings against the United States Treasury or its Disbursing Officers. This cannot be done either directly, or indirectly through the appointment of a sequestrator or receiver or by contempt order against the debtor defendant. *McGrew vs. McGrew*, 59 App. D.C. 230, 38 F. 2d 541.

This is not a question of any right of personal exemption on the part of the defendant Applegate but of the sovereign immunity of the United States from suits to which it has not consented.

In 1969 the tax law was amended to reflect the importance the Congress attributes to support payments by giving them a higher priority than tax liens in the collection of funds.

In 1971, the administration, commenting on a proposal to permit the attachment of retirement pay of military personnel in connection with court orders for child support or alimony, opposed the proposal as extraneous to the bill being considered but noted:

If there is sufficient reason to attach retired pay, the same reason undoubtedly exists for an attachment provision applicable to other Federal pays and annuities. Accordingly, the broader subject of attachment of all Federal pays and annuities for support of dependents may well deserve congressional attention as a matter in its own right. (House Report 92-481, p. 24).

The committee bill would specifically provide that the wages of Federal employees, including military personnel, would be subject to garnishment in support and alimony cases. In addition, annuities and other payments under Federal programs in which entitlement is based on employment would also be subject to attachment for support and alimony payments. This provision would be applicable whether or not the family upon whose behalf the proceeding is brought is on the welfare rolls. It would also override provisions in various social insurance or retirement statutes which prohibit attachment or garnishment.

CHILD SUPPORT UNDER GUARANTEED EMPLOYMENT PROGRAM

A deserted parent participating in the guaranteed job opportunity program could take advantage of the support collection and, where applicable, the paternity determination mechanism provided in the committee bill. The cost of providing these services, however, would be deducted from the amounts recovered and the balance would be turned over to the deserted family.

EFFECTIVE DATES

The collection of support and determination of paternity provision would be effective January 1, 1973.

XI. FISCAL RELIEF FOR THE STATES

Fiscal Relief for the States

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XI. FISCAL RELIEF FOR THE STATES

The committee recognizes that the growth of the welfare rolls over the past several years has been one of the most significant factors in bringing about the fiscal crisis currently facing State and local governments. Just in the past five years, non-Federal costs for the program of Aid to Families with Dependent Children have more than tripled from \$1.1 billion in fiscal year 1968 to an estimated \$3.6 billion in fiscal year 1973. In view of the fact that much of the runaway growth of the welfare rolls is directly attributable to increased Federal interference—both by the Federal courts and by the Department of Health, Education, and Welfare—with the State control of welfare programs, the committee has carefully designed several elements of the bill in such a way that the fiscal burden on the States will be substantially lightened while at the same time the States' control over family welfare programs will be strengthened rather than weakened.

Much of the fiscal relief provided by the committee bill will be an indirect result of the improvements which the bill makes in the general structure of the welfare programs. Most significantly, the guaranteed employment program will reverse what may be the single most important factor in the growth of welfare costs and caseloads by making work once again more attractive than welfare. Similarly, the committee is convinced that the provisions strengthening the mechanisms for collecting child support will have a substantial impact on State costs both as a result of the actual collections made and as a result of the fact that individuals will no longer be able to feel free to have and abandon children with no likelihood of being held responsible for their support. Finally, considerable indirect fiscal relief may be expected from the committee's decisions reversing many of the incorrect interpretations of Congressional intent which the courts and the Department of Health, Education, and Welfare have in recent years used to force the States to expand the welfare rolls.

The committee is, however, aware that State and local governments also desire and need more direct and immediate forms of relief from their welfare burdens. The committee bill provides such relief.

The committee bill will provide close to \$3.5 billion in fiscal relief to the States in the 2½ years between July 1972 and December 1974 as a direct result of the changes in the funding of the cash assistance programs.

The fiscal relief for each State under the committee bill is summarized in table 1. Overall, an estimated \$2.3 billion in fiscal relief would be provided in 1974, once the employment program approved by the committee goes into effect. This contrasts with comparable savings of \$1.9 billion under H.R. 1 as it passed the House. The committee also provided for more than \$400 million in fiscal relief in the last six months of calendar year 1972 and more than \$800 million in fiscal

relief in 1973; both savings figures relate to Aid to Families with Dependent Children.

In summary, the committee bill would provide these savings to the States:

[Dollars in billions]

	1972	1973	1974	Total
Aid to the Aged, Blind, and Disabled.....	.....	.....	\$0.9	\$0.9
Aid to Families with Dependent Children.....	0.4	0.8	1.4	2.6
Total.....	0.4	0.8	2.3	3.5

The details of the committee bill are shown in the material following table 1.

TABLE 1.—STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974 ¹

[In millions of dollars]

State	Committee bill			Estimated savings under House bill
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	
Total	853.1	1,378.9	2,232.0	1,859.2
Alabama.....	20.9	12.9	33.8	31.1
Alaska.....	2.1	2.9	5.0	3.5
Arizona.....	10.0	32.0	42.0	40.5
Arkansas.....	9.2	7.5	16.7	21.5
California.....	200.0	163.3	363.3	180.9
Colorado.....	3.0	15.3	18.3	16.5
Connecticut.....	4.0	11.5	15.5	16.7
Delaware.....	3.8	3.7	7.5	4.7
District of Columbia.....	13.0	45.4	58.4	50.8
Florida.....	30.0	90.3	120.3	135.3
Georgia.....	24.0	36.5	60.5	58.9
Hawaii.....	3.5	8.7	12.2	9.4
Idaho.....	1.1	1.8	2.9	2.0
Illinois.....	20.0	100.6	120.6	167.0
Indiana.....	7.8	29.2	37.0	28.2

See footnote at end of table.

TABLE 1.—STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974¹—Continued

[In millions of dollars]

State	Committee bill			Estimated savings under House bill
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	
Iowa.....	18.0	10.1	28.1	22.7
Kansas.....	2.4	13.2	15.6	12.1
Kentucky.....	14.0	10.8	24.8	15.3
Louisiana.....	31.0	39.5	70.5	68.8
Maine.....	4.1	3.2	7.3	2.5
Maryland.....	16.0	52.8	68.8	72.3
Massachusetts.....	23.0	39.9	62.9	64.8
Michigan.....	14.0	94.9	108.9	97.4
Minnesota.....	8.0	14.5	22.5	17.5
Mississippi.....	14.0	5.5	19.5	20.8
Missouri.....	13.0	15.0	28.0	10.8
Montana.....	2.0	1.7	3.7	1.7
Nebraska.....	1.2	4.4	5.6	7.1
Nevada.....	-0.2	1.9	1.7	1.7
New Hampshire.....	3.0	1.2	4.2	2.2

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New Jersey.....	14.6	30.0	44.6	48.5
New Mexico.....	3.7	3.6	7.3	3.7
New York.....	90.0	135.8	225.8	168.3
North Carolina.....	18.0	16.7	34.7	31.2
North Dakota.....	2.4	2.2	4.6	1.2
Ohio.....	28.0	94.0	122.0	103.0
Oklahoma.....	30.6	14.1	44.7	39.0
Oregon.....	6.2	14.9	21.1	15.4
Pennsylvania.....	46.0	57.1	103.1	70.0
Rhode Island.....	2.3	9.4	11.7	7.1
South Carolina.....	5.5	7.0	12.5	12.9
South Dakota.....	-0.8	1.4	0.6	1.4
Tennessee.....	12.0	16.3	28.3	26.8
Texas.....	39.0	32.5	71.5	44.8
Utah.....	2.3	5.6	7.9	5.2
Vermont.....	0.7	1.6	2.3	3.7
Virginia.....	5.6	12.1	17.7	20.8
Washington.....	15.1	14.6	29.7	12.0
West Virginia.....	7.9	7.0	14.9	14.4
Wisconsin.....	7.6	32.0	39.6	44.6
Wyoming.....	0.5	.8	1.3	.5

\$20

¹ Based on fiscal year 1974 data. Column 4 does not reflect the 20-percent social security increase enacted in June. Column 1 assumes that the States supplement the Federal payments so as to maintain current assistance levels for present recipients of aid to the aged, blind, and disabled. In a few States with high assistance levels there are a number of aged, blind, and disabled persons with incomes below these levels who do not now receive assistance but would be eligible for supplemental security income payments. If these States extended supplementary payments to these newly eligible individuals, there would be additional State costs not reflected in this table. Altogether these added State costs would reduce the total fiscal relief to the States by less than \$0.1 billion.

Aid to the Aged, Blind, and Disabled

Effective January 1, 1974, the Committee bill establishes a new Supplemental Security Income program for aged, blind, and disabled persons. This program will be Federally administered by the Social Security Administration and will be funded entirely by the Federal Government. Under this program, an aged, blind, and disabled person will be assured a monthly income of at least \$130 (\$195 for a couple). In addition the first \$50 of social security or other income will be disregarded so that aged, blind, and disabled social security beneficiaries will have an income of at least \$180 (\$245 for a couple). In addition, there will be other disregards applicable to part of the earned income of beneficiaries.

These income levels under the new Federal program for the aged, blind, and disabled are such that they will largely replace the payments now being made to the needy, aged, blind, and disabled under State public assistance programs for people in these categories. Since the funding of these current assistance programs is partly Federal and partly non-Federal, the new program will represent a considerable savings to the States. Table 2 shows the impact on each State's expenditures which the new Federal Supplemental Security Income program will have. There are some States which now provide a higher level of income supplementation under their assistance programs than will be provided under the new Federal program. Such States will be free to supplement the new Federal program in order to continue current income levels for their aged, blind, and disabled citizens, and Table 2 assumes that they do so. (States would, of course, also be free to use a part of their savings to provide supplementation which exceeds present levels.)

In addition to the \$0.9 billion savings shown in Table 2 as a result of reduced State costs for public assistance payments to the aged, blind, and disabled, it may be expected that the States will save a large part of the \$200 million which they now spend in administering these programs. Even if a State elects to supplement the Federal Supplemental Security Income Payments, it can do so virtually without administrative costs since the Committee bill authorizes agreements between the States and the Department of Health, Education, and Welfare for Federal administration of State supplemental payments without cost to the States.

TABLE 2.—IMPACT ON STATES OF COMMITTEE BILL WITH RESPECT
TO THE AGED, BLIND, AND DISABLED IN 1974 ¹

[Dollars in millions]

State	State costs under com- mittee bill (1)	State costs under current law (2)	State savings (3)
Total.....	513.6	1,366.7	853.1
Alabama.....	6.1	27.0	20.9
Alaska.....	1.9	4.0	2.1
Arizona.....	0	10.0	10.0
Arkansas.....	3.8	13.0	9.2
California.....	180.0	380.0	200.0
Colorado.....	16.0	19.0	3.0
Connecticut.....	9.0	13.0	4.0
Delaware.....	.4	4.2	3.8
District of Columbia.....	0	13.0	13.0
Florida.....	0	30.0	30.0
Georgia.....	0	24.0	24.0
Hawaii.....	.1	3.6	3.5
Idaho.....	.8	1.9	1.1
Illinois.....	43.0	63.0	20.0
Indiana.....	.7	8.5	7.8

TABLE 2.—IMPACT ON STATES OF COMMITTEE BILL WITH RESPECT TO THE AGED, BLIND, AND DISABLED IN 1974 ¹—Continued

[Dollars in millions]

State	State costs under committee bill (1)	State costs under current law (2)	State savings (3)
Iowa	0	18.0	18.0
Kansas	4.1	6.5	2.4
Kentucky	0	14.0	14.0
Louisiana	0	31.0	31.0
Maine	0	4.1	4.1
Maryland	0	16.0	16.0
Massachusetts	38.0	61.0	23.0
Michigan	35.0	49.0	14.0
Minnesota	6.0	14.0	8.0
Mississippi	0	14.0	14.0
Missouri	19.0	32.0	13.0
Montana	0	2.0	2.0
Nebraska	3.0	4.2	1.2
Nevada	1.4	1.2	-.2
New Hampshire	1.7	4.7	3.0

See footnotes at end of table.

New Jersey.....	9.4	24.0	14.6
New Mexico.....	0	3.7	3.7
New York.....	100.0	190.0	90.0
North Carolina.....	0	18.0	18.0
North Dakota.....	0	2.4	2.4
Ohio.....	0	28.0	28.0
Oklahoma.....	1.4	32.0	30.6
Oregon.....	0	6.2	6.2
Pennsylvania.....	6.0	52.0	46.0
Rhode Island.....	2.1	4.4	2.3
South Carolina.....	0	5.5	5.5
South Dakota.....	2.1	1.3	-.8
Tennessee.....	0	12.0	12.0
Texas.....	0	39.0	39.0
Utah.....	0	2.3	2.3
Vermont.....	2.3	3.0	.7
Virginia.....	5.4	11.0	5.6
Washington.....	5.9	21.0	15.1
West Virginia.....	0	7.9	7.9
Wisconsin.....	9.0	16.6	7.6
Wyoming.....	0	.5	.5

¹ Based on fiscal year 1974 data. Table assumes that the States supplement the Federal payments so as to maintain current assistance levels for present recipients of aid to the aged, blind, and disabled. In a few States with high assistance levels there are a number of aged, blind, and disabled persons with incomes below these levels who do not now receive assistance but would be eligible for supplemental security income payments. If these States extended supplementary payments to these newly eligible individuals, there would be additional State costs not reflected in this table. Altogether these added State costs would reduce the total fiscal relief to the States by less than \$0.1 billion.

Federal Funding of Aid to Families With Dependent Children

Under the committee bill, the Federal Government would make a flat grant to the States as its share of the costs of the Aid to Families with Dependent Children (AFDC) program:

For the last 6 months of calendar year 1972 and for calendar year 1973, this grant would be based on the funding for calendar year 1972. The grant for 1973 would equal the 1972 Federal share, plus an additional amount equal to one-half of the 1972 State share, or if less the amount needed in 1972 to bring family income up to \$1,600, \$2,000, or \$2,400 for families with two, three, or four or more members, respectively. In no case, however, would the Federal block grant be less than 110 percent of the Federal share in 1972. For the last 6 months of calendar year 1972, the grant would be one-half of the 1973 grant.

After the employment program becomes effective in January 1974, the Federal grant for AFDC would be reduced somewhat in recognition of the fact that families with no children under age 6 would no longer be eligible to receive their basic income from AFDC. This reduced grant would remain the same in future years, except that it would be increased or decreased to reflect changes in total State population.

For example, the Federal block grant for AFDC in California would be \$689.4 million in 1973. After the employment program becomes effective, this would be reduced to \$526.7 million. The \$526.7 million would remain as the annual amount of the Federal grant to California for AFDC except that it would be adjusted each year to reflect any percentage increase or decrease in the State's population.

Tables 3 and 4 illustrate the effects of the committee bill before and after the employment program becomes effective. The amounts shown in these tables are estimated on the basis of the best information that was available.

FISCAL RELIEF FOR THE STATES IN THE LAST 6 MONTHS OF CALENDAR YEAR 1972

In the last 6 months of calendar year 1972, the committee bill would save the States more than \$400 million, as shown in column 1 of table 3. Since the exact amount under the formula cannot be determined until after the end of calendar year 1972, an amount estimated to equal 75 percent of the State entitlement would be paid within two months of enactment, with the final accounting and payment due by April 1, 1973.

FEDERAL FUNDING IN CALENDAR YEAR 1973

Table 3 also shows the impact of the committee bill in 1973. Columns 2 through 4 show the current law costs for fiscal year 1973. Using these fiscal year 1973 current law costs as the base, columns 5 through 7 show the effect of the committee bill. Column 5 shows the amount of the Federal block grant. Column 6 shows the amount that the States would be required to pay to maintain current assistance levels, and column 7 shows the amounts the States would save by comparison with current law.

TABLE 3.—IMPACT OF COMMITTEE BILL ON STATE AFDC COSTS FOR 1972 AND 1973

[In millions of dollars]

State	Fiscal year 1973						
	1972 State and local savings (1)	Total cost (2)	Current law		Committee bill		
			Federal share (3)	State and local share (4)	Federal share (5)	State and local share (6)	State and local savings (7)
Total.....	410.8	7,973.5	4,379.7	3,594.1	5,201.4	2,772.4	821.5
Alabama.....	3.0	55.4	43.4	11.9	49.5	5.9	6.0
Alaska ¹	1.3	11.5	3.7	7.7	6.4	5.1	2.6
Arizona ¹	12.6	65.5	28.7	36.8	53.8	11.7	25.1
Arkansas.....	1.8	33.6	26.6	6.9	30.2	3.4	3.5
California.....	39.9	1,219.0	609.5	609.5	689.4	529.6	79.9
Colorado.....	5.4	68.9	39.7	29.2	50.4	18.5	10.7
Connecticut.....	2.6	106.6	53.3	53.3	58.6	48.0	5.3
Delaware.....	1.6	15.7	9.2	6.6	12.4	3.3	3.3
District of Columbia.....	16.9	135.7	67.8	67.8	101.8	33.9	33.9
Florida.....	25.5	259.3	157.3	102.0	208.3	51.0	51.0
Georgia.....	9.4	154.2	116.7	37.5	135.5	18.7	18.8
Hawaii.....	3.0	38.4	19.5	18.9	25.4	13.0	5.9
Idaho.....	.6	17.3	12.4	4.9	13.6	3.7	1.2
Illinois.....	25.4	653.2	326.6	326.6	377.3	275.9	50.7
Indiana.....	13.0	114.9	63.3	51.7	89.1	25.8	25.9

See footnote at end of table.

Iowa.....	3.1	60.0	34.8	25.2	41.0	19.0	6.2
Kansas.....	4.9	64.8	38.2	26.5	48.1	16.7	9.8
Kentucky.....	4.6	65.4	47.0	18.4	56.2	9.2	9.2
Louisiana.....	9.2	137.9	101.3	36.6	119.6	18.3	18.3
Maine.....	2.8	36.8	25.6	11.2	31.2	5.6	5.6
Maryland.....	19.2	137.8	61.0	76.8	99.4	38.4	38.4
Massachusetts.....	8.5	340.9	170.4	170.4	187.5	153.4	17.0
Michigan.....	28.0	467.0	233.5	233.5	289.6	177.4	56.1
Minnesota.....	3.6	124.4	70.7	53.7	77.8	46.6	7.1
Mississippi.....	1.2	30.0	24.9	5.1	27.5	2.5	2.6
Missouri.....	7.0	96.5	68.8	27.7	82.7	13.8	13.9
Montana.....	.7	11.5	7.7	3.8	9.1	2.4	1.4
Nebraska.....	1.8	27.5	13.0	14.5	16.7	10.8	3.7
Nevada.....	.8	10.0	6.8	3.2	8.4	1.6	1.6
New Hampshire.....	.4	13.9	8.2	5.6	9.1	4.8	.8
New Jersey.....	8.7	348.6	174.3	174.3	191.7	156.9	17.4
New Mexico.....	1.5	24.7	18.8	5.9	21.8	2.9	3.0
New York.....	29.8	1,190.3	595.1	595.1	654.7	535.6	59.5
North Carolina.....	5.2	76.8	56.0	20.9	66.4	10.4	10.5
North Dakota.....	.6	11.2	8.0	3.2	9.3	1.9	1.3
Ohio.....	35.0	277.7	137.9	139.8	207.8	69.9	69.9
Oklahoma.....	5.2	56.7	35.8	20.9	46.3	10.4	10.5
Oregon.....	5.6	60.8	34.9	25.9	46.0	14.8	11.1
Pennsylvania.....	15.6	562.5	311.9	250.6	343.1	219.4	31.2
Rhode Island.....	3.2	43.6	21.9	21.7	28.3	15.3	6.4

TABLE 3.—IMPACT OF COMMITTEE BILL ON STATE AFDC COSTS FOR 1972 AND 1973—Continued

[In millions of dollars]

State	Fiscal year 1973						
	1972 State and local savings	Total cost	Current law		Committee bill		
			Federal share	State and local share	Federal share	State and local share	State and local savings
(1)	(2)	(3)	(4)	(5)	(6)	(7)	
South Carolina.....	1.6	32.8	26.3	6.5	29.6	3.2	3.3
South Dakota.....	.6	16.6	11.6	5.0	12.8	3.8	1.2
Tennessee.....	4.6	75.8	57.5	18.3	66.7	9.1	9.2
Texas.....	13.2	199.6	147.1	52.5	173.4	26.2	26.3
Utah.....	2.0	32.8	23.1	9.7	27.0	5.8	3.9
Vermont.....	.6	20.4	13.2	7.2	14.5	5.9	1.3
Virginia.....	3.6	113.4	72.6	40.8	79.9	33.5	7.3
Washington.....	2.9	116.7	58.3	58.3	64.2	52.5	5.8
West Virginia.....	2.0	33.9	26.1	7.8	30.0	3.9	3.9
Wisconsin.....	11.5	105.3	59.2	46.0	82.3	23.0	23.0

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¹ Under the committee bill the Federal grant for Arizona and Alaska would be computed under the formula described on the page preceding the table except that current law costs would be assumed to be funded under the medicaid matching formula which is not now available to those 2 States.

FEDERAL FUNDING IN CALENDAR YEAR 1974 AND THEREAFTER

Table 4 shows how the committee bill would work after the employment program becomes effective, except that it does not take account of any increases related to population growth. Column 1 shows the Federal grant for 1973 as it would be reduced to take account of the number of families with no children under age 6. Specifically, the Federal grant would be reduced by 10 percentage points less than the percentage of the AFDC caseload representing families no longer eligible to receive their basic income from welfare once the employment program becomes effective. This 10 percentage point factor in effect represents revenue sharing since the reduction in the Federal grant does not fully reflect the impact of initiating the employment program on reducing welfare costs. Column 2 shows the State costs under the committee bill and column 3 shows State costs under current law. Net State savings (column 3 minus column 2) are shown in column 4. States would enjoy additional savings to the extent that mothers with children under age 6 elect to voluntarily participate in the employment program instead of staying on welfare, and to the extent that States take advantage of their greater flexibility under the committee bill to tighten administration of their AFDC programs.

TABLE 4.—IMPACT OF COMMITTEE BILL ON 1974 STATE COSTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN

[In millions of dollars]

	Federal grant	State costs under committee bill ¹	State costs under current law	State savings ¹
	(1)	(2)	(3)	(4)
Total.....	3,679.9	2,504.9	3,883.7	1,378.9
Alabama.....	29.1	0	12.9	12.9
Alaska.....	4.2	5.4	8.3	2.9
Arizona.....	37.0	7.8	39.8	32.0
Arkansas.....	16.3	0	7.5	7.5
California.....	526.7	494.9	658.2	163.3
Colorado.....	39.1	16.2	31.5	15.3
Connecticut.....	44.3	46.1	57.6	11.5
Delaware.....	9.7	3.4	7.1	3.7
District of Columbia.....	75.2	27.9	73.3	45.4
Florida.....	131.4	19.9	110.2	90.3
Georgia.....	83.6	4.0	40.5	36.5
Hawaii.....	19.5	11.7	20.4	8.7
Idaho.....	9.9	3.5	5.3	1.8
Illinois.....	282.6	252.1	352.7	100.6
Indiana.....	55.9	26.6	55.8	29.2
Iowa.....	27.0	17.1	27.2	10.1
Kansas.....	34.7	15.4	28.6	13.2
Kentucky.....	30.3	9.1	19.9	10.8
Louisiana.....	64.1	0	39.5	39.5
Maine.....	19.0	9.0	12.2	3.2
Maryland.....	77.0	30.1	82.9	52.8
Massachusetts.....	141.2	144.2	184.1	39.9
Michigan.....	206.8	157.3	252.2	94.9
Minnesota.....	52.5	43.5	58.0	14.5
Mississippi.....	17.6	0	5.5	5.5
Missouri.....	53.4	14.9	29.9	15.0
Montana.....	6.3	2.4	4.1	1.7
Nebraska.....	11.4	11.2	15.6	4.4
Nevada.....	6.6	1.5	3.4	1.9
New Hampshire.....	6.1	4.9	6.1	1.2
New Jersey.....	136.5	158.2	188.2	30.0
New Mexico.....	15.1	2.8	6.4	3.6
New York.....	493.0	506.9	642.7	135.8
North Carolina.....	38.5	5.8	22.5	16.7
North Dakota.....	6.1	1.3	3.5	2.2

See footnote at end of table.

TABLE 4.—IMPACT OF COMMITTEE BILL ON 1974 STATE COSTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN—Con.

	Federal grant	State costs under committee bill ¹	State costs under current law	State savings ¹
	(1)	(2)	(3)	(4)
Ohio.....	150.0	57.1	151.0	94.0
Oklahoma.....	30.0	8.4	22.5	14.1
Oregon.....	33.8	13.1	28.0	14.9
Pennsylvania.....	252.9	213.5	270.6	57.1
Rhode Island.....	21.5	14.0	23.4	9.4
South Carolina.....	14.3	0	7.0	7.0
South Dakota.....	8.9	4.0	5.4	1.4
Tennessee.....	41.5	3.4	19.7	16.3
Texas.....	112.0	24.2	56.7	32.5
Utah.....	21.4	4.9	10.5	5.6
Vermont.....	10.6	6.2	7.8	1.6
Virginia.....	50.7	32.0	44.1	12.1
Washington.....	45.1	48.4	63.0	14.6
West Virginia.....	19.0	1.4	8.4	7.0
Wisconsin.....	58.4	17.7	49.7	32.0
Wyoming.....	2.1	1.5	2.3	.8

¹ Where State costs under the committee bill are shown as zero, the amount of the Federal grant may actually exceed the costs of AFDC payments by a small amount. In these cases, the State would benefit from any such excess in addition to saving the full amount of its current law costs shown in column 4.

XII. COST OF PROGRAMS FOR FAMILIES

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COST OF PROGRAMS FOR FAMILIES

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XII. COST OF PROGRAMS FOR FAMILIES

Costs in the First Full Year

The total cost of the committee's program for families is estimated at \$11.3 billion for calendar year 1974, the first year the program is fully effective—an increase of \$4.3 billion over the projected cost of current law for that year. The committee's estimates are based on the assumption that the minimum wage will have been raised to \$2 an hour by the time the guaranteed work program becomes effective. Table 1 shows the component elements of this cost.

TABLE 1.—1974 COST OF PROGRAMS FOR FAMILIES UNDER COMMITTEE BILL

[Dollars in billions]

Government employment.....	\$2.6
Wage supplement.....	0.3
10-percent work bonus.....	1.0
Welfare payments.....	3.7
Cost of cashing out food stamps.....	1.8
Child care: Additional.....	0.8
Included in Government employment.....	(0.4)
Services, training.....	0.4
Administration: Additional.....	0.7
Included in Government employment.....	(0.4)
<hr/>	<hr/>
Total.....	11.3
Present law.....	7.0
<hr/>	<hr/>
Net increased cost.....	4.3

The assumptions underlying the cost estimate for each of these components is described below.

GOVERNMENT EMPLOYMENT

The Department of Health, Education, and Welfare estimates that there will be 3.3 million families eligible for Aid to Families with Dependent Children in 1974. This figure is arrived at by taking the 2.9 million families on the rolls in January of 1972 and projecting an 8-percent annual growth rate. Of this total AFDC caseload, about 40 percent are estimated to be headed either by an able-bodied man (in States which make welfare payments to families headed by an unemployed father) or by an able-bodied woman with no child under 6. The Department also estimates that there are an additional 200,000 families headed by an unemployed, able-bodied father, living in States

which do not pay welfare to families headed by an unemployed father. This makes an estimated 1.5 million eligibles for the guaranteed work program coming from families of the type currently eligible for AFDC. The committee further estimates that approximately 100,000 men in employment who are earning less than the amount paid by the Work Administration would volunteer to participate in the guaranteed employment program.

The committee estimate assumes that 250,000 women heading families who have children under 6 will volunteer to participate in the guaranteed employment program because their benefits under that program would be substantially in excess of the benefits that they would receive under the State AFDC program. Thus the potential participation in the work authority's guaranteed employment program is estimated to be:

TABLE 2.—ESTIMATED TOTAL POTENTIAL PARTICIPATION IN GUARANTEED EMPLOYMENT PROGRAM

	<i>Million</i>
Employable AFDC family heads.....	1.30
Unemployed fathers in States not now paying AFDC to their families.....	.20
Low-income families headed by employed fathers.....	.10
Mothers eligible for AFDC who volunteer.....	.25
Total.....	1.85

This total of potential participants must be reduced by the following:

1. Placement in private employment: The Department of Health, Education, and Welfare has estimated that 200,000 of the participants can be placed immediately in private employment. The committee estimates an additional 250,000 placements resulting from the tax credit for private employers who hire persons from the guaranteed employment program, making a total of 450,000 placements in private employment.
 2. Fifty thousand persons will become regular employees of the Bureau of Child Care.
 3. One hundred thousand persons will become regular employees of the Work Administration (other than in the area of child care).
 4. Not all persons eligible to participate in the guaranteed employment program will participate for all of the eligible hours; a participation rate of 90 percent seems reasonable.
- Applying these reductions, the total man-years for the guaranteed employment program are estimated at 1.1 million, resulting in a cost—when multiplied by \$2,400 per man-year—of \$2.6 billion.

WAGE SUPPLEMENT

The committee estimates that approximately 1 million family heads are employed in jobs paying between \$1.50 and \$2 an hour. The maximum work bonus payable to any worker is 37 cents per hour (three-

quarters of the 50-cent difference between \$1.50 and \$2.00), but since these workers are distributed in jobs paying between \$1.50 and \$1.99 per hour, the committee estimates that the average work bonus will be 22 cents per hour. It is also recognized that low wage workers generally do not work a full work week for 52 weeks a year and the committee has accordingly estimated the wage bonus on the assumption that these workers average 30 hours of work per week over the entire year. Based on these assumptions, the cost of the wage supplement would amount to \$300 million.

WORK BONUS

The cost of the work bonus has been calculated from Internal Revenue Service data, taking into account the amount of social security taxes paid by persons entitled to claim a child as a dependent. This data shows that persons with income under \$3,000 would be entitled to payments of \$269 million; those with incomes between \$3,000 and \$5,000 would be entitled to \$615 million; and those with incomes over \$5,000 would be entitled to \$39 million, making a total cost of \$0.9 billion. This total has been increased by \$100 million to take account of the additional earnings resulting from the new employment generated by the committee's tax credit provision.

FOOD STAMP CASHOUT

The Department of Health, Education, and Welfare estimated the costs of providing the cash equivalent of the food stamp bonus available to poor families at \$1.8 billion, and the committee has accepted that estimate. The estimate is based on the assumption that there are 3.3 million families receiving Aid to Families with Dependent Children and another 1.2 million low-income families eligible for the cashout under the committee bill. With an average food stamp bonus of \$400 per family, the total cost equals \$1.8 billion.

CHILD CARE

The committee bill authorizes \$800 million in appropriations earmarked for child care, but the committee estimates that \$1.2 billion worth of child care will be provided under the bill. This is possible because the Bureau of Child Care will receive the services of 150,000 persons whose salaries will be paid under the guaranteed employment program. The services of these employees (at \$2,400 per year each) equal another \$360 million.

Of the child care funds appropriated, an estimated \$200 million will be devoted to the development of additional child care facilities, with the balance paying for direct care for children.

The employees of the Work Administration will have only school-age children (except for those who volunteer for employment even though they are eligible under State AFDC programs). The committee bill provides that they shall not be assigned to work stations outside their home for the hours their children are out of school, unless care for

their children is available during those hours. Thus after-school care for the children of participants in the guaranteed employment program will be supplied either by a family member or by other participants who will be assigned the duty of supervising not only their own children but also other children of participants who reside in the vicinity. Thus the costs of child care for these children can be borne entirely out of salaries paid to participants in the guaranteed employment program.

Child care for preschool-age children of participants in the guaranteed employment program can also be provided by other participants who will be assigned the task of looking after these children while their mothers are at work.

The 150,000 participants assigned to child care will also be available to supervise the children of the 250,000 persons placed in jobs under the committee's tax credit provision.

The funds appropriated for child care, in addition to being used to develop child care facilities, will primarily be used to subsidize child care for those working mothers who are eligible for the work bonus. In general, these are women who are already working and absorbing the entire costs of child care at the present time. No very accurate estimate number of children involved is possible from available data, and the following estimate is presented only to give an impression of the orders of magnitude involved, and to show that the \$600 million will make a significant contribution toward the pressing need for child care assistance.

Approximately 5 million families are eligible for the work bonus, of whom approximately 1 million are also in the wage supplement program. Of these remaining 4 million families about two-thirds are headed by men, leaving about 1¼ million families headed by women, with an average of two children each. It can further be assumed that at least a quarter of these families can make child care arrangements at no cost through the use of relatives, et cetera. This leaves about 2 million children for whom subsidized child care must be provided.

On the average, then, this will provide about \$300 worth of subsidy per child, a significant contribution to meeting the costs which are currently being absorbed completely by the working mothers. The committee bill provides for the Bureau of Child Care to establish a fee schedule for working mothers who wish to receive child care. The schedule can be modified as the appropriation for child care is increased in future years.

SERVICES AND TRAINING

The committee bill does not assume any expansion above current law expenditures for services and training.

ADMINISTRATION

While the estimate for administrative costs is \$0.7 billion, the Work Administration will also use 150,000 participants in the guaranteed employment program to perform administrative tasks. Including the value of the services of these employees, there will be \$1.1 billion available for administrative costs. The committee estimates that because of

the shifting population in the program and the need for making weekly calculation of the amounts due, administrative costs will equal 12 percent of benefit payments, that is, \$0.5 billion. In addition, \$0.2 billion is the expected Federal share of the costs of administering State welfare programs.

The Work Administration will have additional administrative tasks besides the payment of benefits. The Work Administration must develop work programs, provide supervision for its employees, develop job opportunities and make transportation arrangements; \$0.4 billion is estimated for these administrative tasks.

Five-Year Cost Projections

The cost of the program for families is estimated at \$11.3 billion in calendar year 1974, the first full year of the new guaranteed employment program. The overall costs of the program are expected to increase gradually over the following 3 years. The projections are made on the assumption that there will be only a moderate increase in wage and price levels and no further increase in the minimum wage. The expected costs for the different components of the program are shown in the following table:

TABLE 3.—PROJECTED COST ESTIMATES OF PROGRAMS FOR FAMILIES

[In billions of dollars]

	1973	1974	1975	1976	1977
Welfare payments.....	\$5.2	\$3.7	\$3.7	\$3.7	\$3.8
Government employment.....		2.6	2.6	2.5	2.4
Wage supplement.....	.2	.3	.3	.3	.2
Work bonus.....	.7	1.0	1.1	1.1	1.1
Food stamp cashout.....	1.0	1.8	1.8	1.7	1.6
Child care.....	.8	.8	1.0	1.2	1.4
Services, training.....	.4	.4	.4	.5	.5
Administration.....	.6	.7	.7	.8	.8
Total.....	8.9	11.3	11.6	11.8	11.8
Present law.....	6.4	7.0	7.3	7.7	8.2
Net increase.....	2.5	4.3	4.3	4.1	3.6

Welfare payments.—The amount of the block grant to States is adjusted only for growth in population. The 1973 figure is the amount of the Federal block grant for that year.

Guaranteed employment.—According to the Department of Health, Education, and Welfare's projections of families eligible for the AFDC program, there would be an increase of approximately 100,000 poor mothers with children under 6 in each of the 3 years following 1974. This increase in the basic population participating in the guaranteed employment program would be offset by the following fac-

tors: (1) there would be few further volunteers from low-paid jobs as the movement out of these jobs would occur primarily in the first year; and (2) the tax credit provisions are estimated to result in an additional 250,000 placements each year. However, a substantial increase can be expected in the number of mothers with children under 6 who will wish to participate in the program because of the increase in income which will result for them. Total participation should decline by 1976 as the additional placements exceed the number of new volunteers.

Wage supplement.—The 250,000 additional placements in private industry resulting from the tax credit will produce an increase in the wage supplement in the first year, but this increase is not projected to continue in succeeding years because rising wage levels will both reduce the amount of subsidy payable per placement and will result in a growing percentage of placements in jobs paying more than the minimum wage. These factors are expected to result in a gradual decline in the wage supplement after 1974.

Work bonus.—The cost of the work bonus will be increased by the additional placements in private industry that are anticipated, but this increase will be partially offset at first and totally offset in later years by the general trend of rising wage levels.

Food stamp cashout.—Generally increasing wage levels will operate to decrease the cost of this item as time goes on.

Child care.—Child care costs are projected to increase significantly for two major reasons: (1) an increasing percentage of the participants in the guaranteed employment program will be mothers with children under 6, with a resulting increase in the unit cost of child care; and (2) an increasing number of persons in the wage supplement and work bonus portions of the program will be receiving child care.

Services, training, and administration.—A modest increase in these items is based on expected increases in wage levels and the general price level.

BACKGROUND MATERIAL

The following material prepared by Mr. Robert Myers and by the Department of Health, Education, and Welfare is included in the report to show the detailed background related to the cost estimates. The differences between the two are summarized in table 3 below.

TABLE 4.—COMPARISON OF 1974 COST ESTIMATES RELATED TO PROGRAMS FOR FAMILIES

[In billions of dollars]

	House bill		Committee bill	
	Original HEW estimate	Myers estimate	Original HEW estimate	Myers estimate
Government employment.....			5.7	2.6
Wage supplement.....			1.7	.3
Children's allowance.....			.5	
10-percent work bonus ¹			1.1	1.2
Welfare payments.....	5.1	7.1	3.2	3.7
Cost of cashing out food stamps.....	1.5	1.5	1.8	1.8
Child care: Additional.....	.8	.8	1.5	.8
Included in Government employment.....				(.4)
Public service jobs.....	.8	.8		
Services, training.....	.6	.6	.8	.4
Administration: Additional.....	.7	.7	1.7	.7
Included in Government employment.....				(.4)
Total.....	9.5	11.5	18.0	11.5
Present law.....	7.0	7.0	7.0	7.0
Net increased cost..	2.5	4.5	11.0	4.6

¹ The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.

1. Original Material Prepared by the Department of Health, Education, and Welfare Concerning the Cost of the Committee Bill

INTRODUCTION

The following estimates were prepared by the Department of Health, Education, and Welfare and the Office of Management and Budget. The gross Federal costs of the Senate Finance Committee's alternative welfare proposal are based on the descriptions provided in committee prints 12 and 14 (dated April 12 and April 19, respectively). In many areas, the details of the various programs are not clearly described. In others, there are options suggested rather than a specific plan. This required numerous assumptions in order to arrive at cost estimates.

In all cases, these assumptions are made explicit and a conservative approach was used wherever doubt existed.

The gross total cost of the Senate Finance Committee proposal is \$17.9 billion—or \$9.4 billion over the comparable estimates for H.R. 1. The costs are done on a full-year basis for fiscal year 1974.

TABLE 5.—COST COMPARISON: FINANCE COMMITTEE PROPOSAL VERSUS H.R. 1

[Note: This proposal is compared to H.R. 1 on the basis of gross costs for all family programs (including food stamps, which are cashed out by H.R. 1).]

[In billions of dollars]

	Finance Committee proposal	H.R. 1
Guaranteed employment.....	5.7	} 6.4
10 percent rebate.....	1.1	
Children's allowance ¹.....	.5	
Wage subsidy.....	1.7	
Residual AFDC.....	3.2	
Subtotal.....	12.2	6.4
Food stamps.....	1.8	² .5
Child care (required to work only).....	1.5	³ .7
Services and training.....	.8	.4
Administration.....	⁴ 1.7	.6
Impact on other programs.....	-.1	-.1
Subtotal.....	5.7	⁵ 2.1
Total.....	17.9	⁶ 8.5

¹ Family programs (full year of working poor, no deduction for public jobs).

² While no H.R. 1 recipients receive food stamps, this is the amount paid States through the hold harmless provision as a result of State action to cash out food stamps.

³ To make the costs comparable, the \$800,000,000 in H.R. 1 was adjusted downwards to eliminate the costs for volunteers.

⁴ Gross Federal costs of administration are estimated as follows:

	Billions
Residual welfare program.....	\$0.7
Guaranteed employment.....	.6
10 percent rebate.....	.2
Wage subsidy/children's allowance.....	.2
Total.....	1.7

⁵ The \$800,000,000 for public service jobs is not included, since the Finance proposal refers to funding of public service jobs and may contain a like provision; since it is not included in benefit payments, the net addition to H.R. 1 costs would be \$500,000,000.

⁶ Hold harmless payments not related to the food stamp cash out are not included; inclusion would add some \$200,000,000 more to H.R. 1 costs. The finance proposals will undoubtedly also include a State fiscal relief provision.

I. GUARANTEED EMPLOYMENT

The Senate Finance Committee proposal would provide guaranteed public sector jobs for all employable recipients at 75% of the minimum wage. It is estimated that 1.9 million people would be directly employed by the Federal Employment Corporation, including some 600,000 persons presently working at jobs paying less than the Corporation wage. Based on legislation now before the Congress, a conservative estimate of the minimum wage for fiscal year 1974 is \$2.00 per hour, with the Corporation wage set at \$1.50 per hour.

A. Estimated employees of the Federal Employment Corporation:

(1) Estimated AFDC families in fiscal year 1974 (million).....	1 ¹ 3.3
(2) 40 percent estimated employable by Finance Committee definitions (million).....	1.3
(3) Less direct placements in private employment (million).....	-0.2
(4) Plus unemployed male heads who volunteer (million).....	+0.2
(5) Unemployed persons in guaranteed employ- ment (million).....	1.3
(6) Number of "volunteers" from low-paying jobs (million).....	2 0.6
Total number of corporation employees (million).....	1.9

B. Estimated costs:

1.9 million employees × \$3,000 salary ³ (billion).. \$5.7

¹ The number of actual families on the AFDC rolls as of Jan. 1, 1972, was 2,900,000. This was projected forward at an 8 percent annual growth rate reaching an average for fiscal year 1974 of 3,300,000. The assumed growth rate is roughly half the rate of increase actually experienced over the preceding 5 years.

² Assumes roughly 1/4 of 2,300,000 workers presently earning less than \$1.60 per hour will quit their low-paying jobs and work for the Corporation. The number of total workers now earning less than \$1.50 per hour is derived from 4 separate Labor Department surveys conducted during 1970 and 1971 by the Employment Standards Administration. The number joining the Corporation might even be larger were it not for the 1-month loss of benefits stipulated in the committee print for those who quit work without good cause.

³ \$1.50 per hour times 2,000 hours equals \$3,000.

II. 10 PERCENT SPECIAL INCENTIVE PAYMENT ¹

The \$1.1 billion estimate for the 10% special incentive payment is based on a March 10 computer run done by the Treasury Department's Office of Tax Analysis. The raw estimate, based on the Treasury's computerized tax model, was \$1,213 million. The results of the model were adjusted marginally upward to include non-filing earners and downward to reflect the model's inclusion of all dependents

[¹ The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.]

(rather than children only). These results are consistent with the \$1.1 billion estimate of the Senate Finance Committee.

III. CHILDREN'S ALLOWANCE

Under the Senate Finance Committee proposal, a children's allowance would be payable to all low-income families working substantially full-time. The full allowance would be set at \$25 per month for the fifth family member, \$15 for the sixth, and \$10 for each additional family member. This allowance would only be payable for family members born before July 1, 1973 and would be scaled down at a rate of \$1 in allowance for every \$2 of earnings above annual earnings of \$3,600.

Therefore, the estimate begins with an assumption that only families with income of \$3,000 or over would meet the work test and be eligible for benefits. These benefits would then be a function of income and family size. Census Current Population Reports for 1970 (Series P-60, #80, Table 19) array income by family size and form the basis for the total costs. Summary results are displayed below.

Type of families	Number of families (thousands)	Total benefits (millions)
Working male-headed family.....	600	\$205
Working female-headed family.....	300	107
Former AFDC families in guaranteed employment.....	450	204
Total	1,350	516

IV. WAGE SUBSIDY

Under the Senate Finance Committee proposal, family heads employed at less than the minimum wage would be given a wage subsidy. These workers, earning at least \$1.50 per hour, would receive a wage supplement equal to three-fourths of the difference between their pay and the minimum wage.

Estimates of the cost of this wage subsidy plan assume that the number of heads of families eligible for H.R. 1 and their pattern of work experience are approximately the same as family heads eligible for the wage subsidy. These estimates, derived from the HEW model used in computing H.R. 1 costs, are based on Census Bureau Current Population Survey reports.

	Billions
Total hours of work by eligible participants (2,400,000 workers).....	3.4
Total earnings if paid at \$2 per hour.....	<u>\$6.7</u>
Actual estimated earnings, from H.R. 1 computer run.....	<u>3.8</u>
Difference.....	<u>2.9</u>
Subsidy (75 percent of difference).....	2.2
Less offset from persons who leave private jobs to go into guaranteed employment.....	<u>.5</u>
Total wage subsidy cost.....	1.7

V. RESIDUAL AFDC

The Senate Finance Committee plan would retain the present AFDC program (with some possible modifications) for low-income, female-headed families with no employable members. These would be families in which the father is dead, absent or incapacitated, and in which there would be at least one pre-school age child.

The cost of such a residual program was estimated by an HEW computer model using the same techniques as the one used to derive H.R. 1 costs, but containing State caseloads and payment formulas. The costs were estimated to be \$3.2 billion. As an independent check, the following calculations were made—yielding the same total cost.

In the residual AFDC program, the Federal Government would pay 100% of the amount necessary to bring the family's countable income up to a minimum level—depending on family size.

If the families had no income and their distribution by family size was the same as it is for all AFDC families the average Federal payment would be \$2,064 per family (see table below).

	Percent distribution	Minimum payment
Number of family members:		
2.....	30	\$1,600
3.....	25	2,000
4 or more.....	45	2,400
Total.....	<u>100</u>	<u>¹2,064</u>

¹ Average.

However, about 40% of AFDC families have some income other than assistance. Assuming their countable income averages about \$750, the overall average Federal benefit would be \$1,800.

The number of AFDC families in the residual program in 1974 would be as follows:

	Millions
Gross AFDC families.....	3.3
Less employables.....	-1.3
Less estimated reduction due to stringent eligibility criteria ¹ ..	-.3
Total eligible for residual program.....	1.8
Estimated number of families eligible for Federal matching....	1.8
Times estimated average Federal matching for case	\$1,800
Estimated Federal cost of residual AFDC..... billion.....	\$3.2

¹To be conservative in our figures, a 10-percent reduction in unemployable AFDC recipients is assumed to result from eligibility limitations being planned by the Senate Finance Committee.

VI. FOOD STAMP CASHOUT

Families eligible to participate in the employment programs of the Senate Finance Committee plan would lose their eligibility for food stamps. H.R. 1 has a similar provision. As in H.R. 1, the Senate Finance Committee proposal would assure States that the Federal Government would pay the full costs of State supplements to recipients necessary to make up for their loss of entitlement to food stamps.

(1) Eligible families:	Millions
AFDC ¹	3.3
Working poor ²	1.2
Total	4.5
(2) Average food stamp bonus per family.....	³ \$400
(3) \$400 times 4,500,000 families.....	⁴ \$1,800,000

¹ See No. I above for derivation of this projection.

² From HEW model used to estimate H.R. 1 costs and caseload (table 10).

³ This actually understates the current average bonus which is about \$40 per family per month.

⁴ If the committee plan is modified to prohibit families who participate in the wage subsidy program from further receipt of food stamps without compensating them, the costs could be reduced by \$500,000,000—the full amount of the benefits lost to the family (\$400 times \$1,200,000 equals \$480,000,000).

Under the Finance Committee alternative, the Federal Employment Corporation would have to provide child care for the children of AFDC mothers deemed employable.

(1) Estimate number of families requiring care:	
40 percent of 3,300,000 AFDC families are considered "employable" (millions).....	1.3
Less 30 percent who have no children under 12 years of age (million).....	-.4
Total families requiring child care (million).....	.9
(2) Multiply by the average number of children per family....	2.3
(3) Total children requiring child care (millions).....	2.1
(4) Multiply by annual cost of child care for school age children	¹ \$800
(5) Equals total potential child care costs (billions).....	\$1.7
(6) Less possible offset.....	² -.2
Estimated cost of child care (billions).....	\$1.5

¹ The \$800 per child-year for part-time care (full time during the summer when school is out) is the figure used for H.R. 1 for a level of care superior to custodial, but not fully comprehensive.

² This 12-percent reduction reflects the possibility of (a) employing AFDC mothers as child care staff or (b) providing more custodial care. No training costs are added for training AFDC mothers as child care workers.

VIII. SERVICES AND TRAINING

Because of the severe financial penalties to a Federal Employment Corporation employee who chooses training ($33\frac{1}{3}$ percent reduction of his \$1.50/hour wage), it is assumed that total training costs will be no more than \$200 million.

TRAINING \$0.2 BILLION

The open-ended employability services and family planning, exclusive of child care, are estimated to cost \$300 per family for the 1.3 million employable family heads and the 600,000 "volunteers" who come into the corporation.

SERVICES \$0.6 BILLION

Note.—Any services offered to non-Corporation employables, such as the direct private market placements or the wage subsidy people (to keep them from coming into the Corporation at greatly increased costs), would constitute added costs.

IX. ADMINISTRATION

Under the Finance Committee alternative, the Federal Government would assume the full administrative cost of five separate programs, four of which would be federally administered, one of which would be State-administered.

Federal programs: ¹	Billions
*Administrative cost of Guaranteed Employment program ¹ .....	. 6
*Administrative cost of wage subsidy.....	. 2
*Children's allowance and tax rebate programs.....	. 2
Total	<u>1. 0</u>

*10 percent of benefit payments.

¹ To retain the conservative bias, this includes only the administrative costs of the distribution function of the wages without the costs of supervision, placement, training, etc.

Total administrative costs under current law for all federally assisted programs in fiscal year 1974 is estimated to be \$1.4 billion. Of this, the Federal share is 50 percent or \$700 million. Under the Finance Committee's alternative, the States would, in order to preserve their option for State administration without fiscal penalty in comparison to choosing Federal administration, be reimbursed for the full costs of administration.

State programs:	Billions
Federal	\$1. 0
State .....	. 7
Total	<u>1. 7</u>

X. IMPACT ON OTHER PROGRAMS

The plan would reduce Federal costs for Cuban refugees and Indians by a total of over \$100 million.

Offset: —\$0.1 billion.

2. Memorandum on Cost Estimates Prepared for the Committee on Finance by Robert J. Myers

June 8, 1972.

Memorandum to: The Honorable Russell B. Long, Chairman, Committee on Finance.

From: Robert J. Myers, Actuarial Consultant.

Subject: Actuarial Cost Analysis of Workfare Program Proposal.

This memorandum will present my analysis of the Workfare Program proposal. This analysis casts considerable light on the cost aspects of the proposal, especially as my results differ from the cost estimates therefor made by the Department of Health, Education, and Welfare.

As part of this study, I shall discuss what I believe to be the weaknesses and deficiencies in the Department of HEW's cost estimates for the Family Assistance Plan (FAP), as contained in H.R. 1, and for the Workfare Program. One problem in considering the Department's cost estimates is that they are changed so frequently without explanation of why the differences have occurred; however, the methodology is generally the same.

A. DEPARTMENT OF HEW COST-ESTIMATING METHODOLOGY FOR FAP

HEW has used the procedure of analyzing what results that FAP would have if it had applied individually to each case in a small sample derived by the interview process several years ago. Several difficulties are involved in this process—and, quite admittedly, there are also difficulties involved in any procedure for making cost estimates for a new and complex program.

Further, there is a question as to the adequacy and validity of the sample. Is it properly representative of the lowest-income population for whom FAP is designed? Who will be the group for whom most costs will be due? How well is income reported in the survey (it is mentioned that the survey is deficient as to the amount of welfare payments reported, but no details are given as to just how much)? How much less well will income be reported once FAP is enacted when there is a financial incentive not to report?

Another very important criticism of the HEW cost estimates is that they make no allowance for persons adjusting their economic conditions to the provisions of the plan. This is bound to occur in any program like FAP that provides benefits on a "rights" basis under a mathematically-determinable basis. This is evidenced by the manner in which social security beneficiaries adjust their earnings to fit in with the retirement test (and changes therein). Another evidence of this was the significant increase in hospitalization of the aged after medicare went into effect as compared with the immediately preceding experience; the actuarial cost estimates that were made initially had

included some allowance for this fact, but not for nearly as much as actually occurred.

There will certainly be great pressure under FAP—and with resultant effect—for eligibles to get rid of income that cause a “\$1 for \$1” reduction and to not report both such income and also earned income in excess of the \$720 annual exempt amount. This factor should be recognized in the cost estimates.

Also, the use of electronic data processing methods—despite their great attractiveness and utility in certain operations, such as mass recordkeeping and tabulation of crude statistics—can quite possibly introduce errors and bias that will be undetected when only the overall results of the procedures are visible (because of possible programming errors and because of gaps of misunderstanding between the estimators and the FAP technicians). Even though completely precise and accurate arithmetical calculations can be made for each case separately, and a completely accurate summation of these results obtained, there is no assurance that such summation will be an accurate portrayal of costs. This is so because such individual-case calculations might not be accurate portrayals of the situation which would result after the program became effective. Thus, each of the basic bits of data are in themselves imprecise, since the static conditions to which they apply would be so vastly changed by what would actually happen when the program goes into operation.

The fact that the social security earnings-record system would be used to police FAP, at least insofar as earnings are concerned, is not of great significance in reducing costs. Much of the earnings of the FAP potential eligibles is not covered or is significantly under-reported (or unreported) because of poor coverage compliance in the areas of domestic, casual, small business, and agricultural work.

Still another important point is with regard to the adjustment made by HEW to allow for non-claiming of FAP benefits. It is likely that there will be some of this, particularly when only small residual benefits are involved, but I doubt greatly whether there will be anywhere near as much as HEW assumes in its report of February 1971, to the House Committee on Ways and Means, “Welfare Reform—Costs and Caseloads” (90 percent where annual benefits are \$200 or less, decreasing to 5 percent where benefits are over \$1,000). If FAP is administered on the basis that I believe likely, great publicity will be made, and beneficiaries will be sought after, so that there will be little non-claiming (as is in income-tax refunds and Social Security benefits). The argument that there is much non-claiming in the New York plan for the working poor is not relevant, since that plan is poorly publicized and also since its payments carry a stigma. It is not at all clear whether or not this non-claiming factor is included in the FAP cost estimates contained in the House Report on H.R. 1 or in subsequent estimates for FAP furnished to the Committee on Finance.

The HEW projections of the cost of FAP curiously show a decreasing trend to recipients and costs as years go by. In fact, this appears to be due to the assumption that FAP benefit amounts will remain static (despite dynamic economic conditions), that there will be significant incentives to leave the welfare rolls for paid employment, and that the working-poor population will decline in size under the dynamic economic assumptions used. With the $66\frac{2}{3}$ percent “tax” on earnings

above the exempt amount, such incentives would seem to be considerably dampened and thus ineffective.

In summary, I believe that the HEW estimates for FAP are significant under-statements of cost, despite the assertions that they are "conservative." On the very surface, it is just not reasonable that such an expansion of the number of welfare recipients will result in so little an increase in cost.

B. COST ESTIMATES FOR H.R. 1

The latest of many changing cost estimates made by HEW shows a total Federal cost for programs for families with children and for the residual food stamp program under H.R. 1 as passed by the House of Representatives of \$8.5 billion for fiscal year 1974. This amount appears to be subdivided as follows:

	Billions
Payments to families (FAP).....	\$5. 8
Food stamps, payments in lieu thereof.....	1. 0
Child care.....	. 5
Services and training.....	. 6
Administration.....	. 7
	<hr/>
Gross total cost.....	8. 6
Impact on other programs (Cuban refugees and Indians).....	- . 1
	<hr/>
Net total cost.....	8. 5

It should be noted that the above cost figures for programs for families with children represent the gross cost of these particular portions of the program. They thus do not show the net costs after allowance has been made for the elimination of existing programs (such as AFDC). The same method of presentation of estimated costs is followed in dealing subsequently with the Workfare program.

Not included in these cost figures are the costs for two other items in H.R. 1 that should properly be included in order to be comparable with the costs later presented for the Workfare program. There is an additional \$300 million for child care representing the cost for the services of women with children under age 6 who volunteer to do such work, and there is an additional \$500 million as the net cost of public service jobs over the public assistance costs otherwise payable to persons in such jobs (which provision is not in the Workfare program).

The resulting net total cost of \$8.4 billion for programs for families with children (i.e., not considering the \$1.0 billion remaining cost for food stamps or the \$.1 billion savings for other programs) according to the adjusted HEW estimate is, in my opinion, too low as a measure of the ongoing permanent-program costs for a number of reasons. First, it includes only a half year of FAP costs for payments to families in which both parents are present and neither is incapacitated and the father is employed; adjustment for this factor would add \$.3 billion. Second, the portion of the "hold harmless" provision cost due to AFDC is not included; adjustment for this factor would add \$.5 billion. Finally, the basic cost for the FAP program is under-estimated because of not recognizing the strong incentives to go onto, and remain on, the program (or conversely not to go off the program because of the

little incentive to earn more); adjustment for this factor would add \$1.2 billion.

Thus, according to my views, the net total cost of programs for families with children under H.R. 1 for fiscal year 1974 would be \$10.4 billion (as compared with the adjusted HEW estimate of \$8.4 billion).

C. COST ESTIMATES FOR WORKFARE PROGRAM

The HEW estimate for the Workfare program for fiscal year 1974, assuming that it would be fully effective throughout this entire year, including the cost for the residual food stamp program and the savings due to the impact on other programs, but exclusive of the Federal cost for the residual AFDC program (which provision was changed after HEW made its cost estimates) is \$14.2 billion, subdivided as follows:

	Billions
Guaranteed job opportunity.....	\$5. 7
Low-wage supplement.....	1. 7
Work bonus of 10 percent.....	¹ 1. 1
Food stamps.....	1. 8
Child care.....	1. 5
Services and training.....	. 8
Administration	1. 7
	<hr/>
Gross total cost.....	14. 3
Impact on other programs.....	- . 1
	<hr/>
Net total cost.....	14. 2

[¹ The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.]

To the above cost there should be added \$3.7 billion, representing the cost of the Federal funding of the residual AFDC program (as estimated in the committee print "Fiscal Relief for States—Explanation of committee decisions," June 5, 1972). This makes a total cost for the Workfare program, according to the HEW estimates, of \$17.9 billion for fiscal year 1974.

In my opinion, the foregoing cost estimate made by HEW is significantly overstated. In large part, this is because of the failure to recognize the work incentives involved in the program and the built-in elements encouraging the full reporting of earnings and because of misunderstanding the full details and implications of the total Workfare proposal.

It should be noted that the HEW estimate for the Workfare program is based on the presumption that the Federal minimum wage will be \$2.00 per hour in fiscal year 1974. I will use this basis in my analysis of how the HEW estimate should be modified and adjusted to produce a more realistic estimate. However, the HEW estimate does not adequately reflect the effects of other changing economic conditions.

1. *Guaranteed Job Opportunity*

The HEW estimate for the Guaranteed Job Opportunity portion of the Workfare program assumes that the estimated families who would be on AFDC in fiscal year 1974 if that program were left unchanged

would be 3.3 million and that 40 percent of them, or 1.3 million, would be "employable" under the definition of the committee. To this 1.3 million would be added, according to the HEW estimate, .2 million unemployed male heads who choose to take employment with the Work Administration (WA), and there would be subtracted .2 million persons who would be direct employment placements in private industry.

Finally, the HEW estimate assumes that 600,000 persons will leave low-paying private jobs (at less than \$1.50 per hour in fiscal year 1974) to obtain the guaranteed employment with the WA.

This estimate, based on 1970 survey data (without apparent adjustment even for increasing wage levels, let alone for the fact that many of these low-earnings jobs are such because of being part-time, for convenience, etc.), is really an arbitrary assumption, and it seems unusually overstated and, at most, should be assumed at only a nominal figure, such as only about 100,000.

In summary then, the HEW estimate for the Guaranteed Job Opportunity provisions is that 1.9 million persons will, on the average, be employed by the WA in fiscal year 1974 (1.3 million from AFDC, plus .2 million unemployed male heads, minus .2 million direct employment placements in private industry, plus .6 million who leave private jobs).

Furthermore, HEW assumes that all persons employed by the WA will work for 40 hours a week and will be paid \$3,000 per year (i.e., 50 weeks of 40 hours per week at \$1.50 per hour). First, it is obvious that not all will choose to work a full 40 hours. Second, the committee, intention is to have the annual pay rate not exceed \$2,400, so that, with the \$1.50 hourly rate of pay, only 32 hours of work would be possible (even so, not all would choose to work this long). Accordingly, I would estimate the comparable cost of the Guaranteed Job Opportunity Program at \$3.0 billion for fiscal year 1974, before taking into account the effect of the provisions for income tax credits to employers who hire employees from the WA for at least two years and the effect of the persons who would otherwise work for the WA but who move out into regular work in the administration of the Workfare program (an assumed 100,000 persons) and in the child care portion of the program (an assumed 50,000 persons).

This cost is based on 1.4 million employees at an annual salary rate of \$2,400, minus a 10-percent adjustment to allow for those not working the maximum possible time of 32 hours: in essence, this means 1.25 million employees on a full-time, or man-year, basis.

The \$2,400 figure used above is merely the prescribed maximum annual wage rate, while the 1.4 million employees used is that derived by HEW in its estimate (1.9 million) reduced by my lower assumption as to the number of persons who will leave private jobs to go to the WA. The adjustment factor of a 10-percent reduction to allow for those not working a full 32-hour week is empirically derived, but seems reasonable (and, if anything, is probably not large enough).

After taking into account the removal from WA employment of 250,000 persons as a result of the income tax credits to employers who hire WA employees for at least two years and the 150,000 persons who would otherwise work for the WA but who move into regular work for the WA in administration or child care, and the addition of an assumed 250,000 "volunteers" from the residual AFDC program, (who prefer the higher WA earnings to AFDC and who thus add to

the WA costs, but do not reduce the Federal cost for the residual AFDC program), the net number of WA employees, on a man-year basis is estimated at 1.1 million. Accordingly, my estimate of the cost of the Guaranteed Job Opportunity Program, after making all appropriate adjustments, is \$2.6 billion for fiscal year 1974.

2. Low-wage Supplement

The low-wage supplement portion of the Workfare program applies to family heads in jobs not covered by the Federal minimum wage law who earn at least 75 percent of the minimum wage prescribed thereunder, but less than such minimum wage. This program would, in my opinion, have the effect that any wages below such 75 percent point would be raised thereto, so as to qualify for the low-wage supplement. The HEW estimate is based on 2.4 million workers falling into this category, working on average of only 27 hours per week at only \$1.10 per hour. These data are inconsistent with the conditions established in the proposal, which are that benefits are paid only to those with wages of at least \$1.50 per hour, and no account is taken of rising wage trends up to 1974. Thus, the average wage supplement used in the HEW estimate amounts to about \$.68 per hour (75 percent of the excess of \$2.00 over \$1.10), whereas the most that it can be is \$.38 (75 percent of the excess of \$2.00 over \$1.50), and the average will probably be about \$.20.

I believe that, under the low-wage supplement provisions, not more than 1.0 million workers would be involved, on the average, over the course of a year, with an average supplement of about \$.22 per hour for an average work week of about 30 hours. This yields a total annual cost of \$.3 billion for the low-wage supplement provisions. The figure of 1.0 million eligible workers on the average is derived from Social Security earnings data, taking into account the facts that the supplements are payable only to family heads who are employees (i.e., excluding the self-employed) and that some with very low amounts due will not apply for them; also, projection of the wage levels in the tabulated data was made to what they will likely be in fiscal year 1974.

The average supplement is assumed at \$.22 per hour, since the supplement can range from \$.01 to \$.38, and it will be somewhat higher than the midpoint of \$.19½, because there will be less likelihood of people applying for very low amounts. The assumption as to an average work week of 30 hours seems reasonable for low-income persons such as would benefit under these provisions and is consistent with the corresponding HEW figures of 27 hours.

3. Work Bonus

The cost estimate of \$1.1 billion for fiscal year 1974 for the Work Bonus of 10 percent for low-earnings workers that was made both by the Committee on Finance and by the Office of Tax Analysis Treasury Department,¹ seems reasonable and was confirmed by independent calculations that I made using projected social security earnings data for past years. To this however, must be added \$.1 billion to allow for the estimated 250,000 workers who transfer from the WA to private employment as a result of the provisions for income tax credits to employers who hire WA employees for at least 2 years.

¹The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.]

4. Food Stamps Provisions

As to the Food Stamp provisions of the Workfare program, HEW estimates a cost therefor of \$1.8 billion for fiscal year 1974. As indicated previously, this is not entirely—but rather only partially—a new cost, since \$1.0 billion thereof relates to persons who would be receiving such benefits if present law were left unchanged, and the remaining \$.8 billion represents the payment of the equivalent of the value of food stamps to persons not now receiving them, even though in a category eligible.

I believe that, in the aggregate, the HEW estimate is reasonably good. The number of eligible families seems somewhat too high (because of over-estimating the number of eligible working poor) but this is counterbalanced by the average value of the food stamps for which payments in lieu are made being assumed somewhat too low.

5. Child Care

As to the HEW cost estimates for the Child Care provisions under Workfare, the total children requiring child care (children between ages 6 and 12) is derived by multiplying the 900,000 families with any children at these ages by an average of 2.3 children per family. The latter factor is far too high because it should represent the average number of children aged 6–11 per family in families with such children; the proper factor is probably about 1.8 children per family based on my analysis of census and social security data. Thus, my estimate of the total potential child care costs is \$1.4 billion for fiscal year 1974 (based on the HEW estimate of 900,000 families requiring child care, times the above-mentioned 1.8 children per family, times the HEW estimate of \$800 as the annual cost of child care per child).

But there should be an offset against this total potential cost to allow for employing persons under the Guaranteed Job Opportunity Program to run a substantial part of the Child Care program. The HEW estimate allows only 12 percent for this factor. I believe that an allowance of as much as 40 percent is actually reasonable (which includes \$150 million representing the wages for the estimated 50,000 persons moved from WA employment to regular employment in this program, but which does not include the sizable number of persons who would work in this program but who would remain as WA employees).

6. Services and Training

The HEW cost estimate for services and training for the Workfare program for fiscal year 1974 is \$.8 billion (\$.2 billion for training and \$.6 billion for services), as against only \$.6 billion for H.R. 1 (\$.5 billion for training and \$.1 billion for services).

In my opinion, since the emphasis is on work and on training while working, the cost for training will probably be only about \$.1 billion. The HEW estimated cost for services seems too high, both in relation to the similar cost under H.R. 1 and in absolute terms. Thus, the unit cost of \$300 per year per family seems overstated, and then this is applied to 1.9 million families. (As mentioned earlier, I believe that the best estimate of the net number of full-time workers under the Guaranteed Job Opportunity Program is 1.1 million, not 1.9 million.) Accordingly, I estimate the cost for training for fiscal year 1974 is about \$.3 billion.

7. Administration

As to administrative costs, the HEW estimate assumes such costs to be 10 percent of the payments under the Guaranteed Job Opportunity, Low-wage Supplement, and Work Bonus Programs. Considering the complex nature of these programs and the flow of people in and out of them a higher administrative expense ratio, such as 12 percent, seems more reasonable. Applying this latter ratio to my estimates for each of these programs yields a figure of \$.4 billion (as compared with HEW's figure of \$1.0 billion) for fiscal year 1974. This figure allows for a substantial part of the administrative work being performed by WA employees, the cost for whom is included in the cost of the Guaranteed Job Opportunity Program.

Further, as to administrative expenses, such costs will be increased as a result of the Federal Government paying the full State administrative expenses for any supplemental payments. HEW estimates this element for fiscal year 1974 to be half of the \$1.4 billion administrative expenses for the present federally-assisted programs (or \$.7 billion), since the States would pay such amounts under present law. This seems entirely too much since it represents administrative expenses for the adult categories and for medicaid, in addition to those for the AFDC category. The proper amount for these administrative expenses of the residual AFDC would be about \$.2 billion for fiscal year 1974, according to my estimate.

8. Tax Credits for Employers

The Joint Committee on Internal Revenue Taxation has estimated that the previously-mentioned income-tax credits for employers who hire WA employees will have an annual cost of \$200 million (which at \$800 per person means 250,000 jobs).

9. Summary

In summary, the estimated cost for the Workfare program, as I have modified and corrected the HEW estimates, may be summarized as follows for fiscal year 1974, assuming that the program is fully effective throughout the entire year:

	Billion
Guaranteed job opportunity.....	\$2.6
Low-wage supplement.....	.3
Work bonus of 10 percent.....	1.2
Residual AFDC.....	3.7
Food stamps cash-out.....	1.8
Child care.....	.8
Services and training.....	.4
Tax credits for employers.....	.2
Administrative expenses.....	.7
Gross total cost.....	11.7

[¹ The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.]

In summary, my analysis of the gross costs of the program for families with children under H.R. 1 and under the Workfare program for fiscal year 1974 (assuming that the program will be fully

effective throughout the entire year) may be presented as follows (in billions) :

Program	HEW estimate	My estimate
H.R. 1.....	\$8.4	\$10.4
Workfare.....	17.8	11.7
Increase of workfare over H.R. 1.	9.4	1.3

As to net costs under H.R. 1, and under the committee proposals as they relate to programs for families with children and to the food stamp program as it applies to such families for fiscal year 1974 (assuming that the program will be fully effective throughout the entire year), there are the following data according to my estimates.

[In billions]

	H.R. 1	Workfare
Gross cost.....	\$10.4	\$11.7
Less food stamp cost ¹	-1.1	-1.1
Less impact on other programs ²	-.1	-.1
Less cost of present AFDC ³	-5.7	-5.7
Less present employer tax credits ⁴		-.1
Net cost.....	3.5	4.7

¹ Cost of present food stamp program for families with children only.

² Reduction in cost for programs for Cuban refugees and Indians.

³ Includes payments to recipients, child-care costs, training costs, and administrative expenses.

⁴ H.R. 1 would not eliminate these provisions; the committee proposal would substitute a new basis.

3. Material Prepared by Department of Health, Education, and Welfare in Response to Myers Memorandum

A. INTRODUCTION

On June 12, 1972, the Senate Finance Committee issued a committee print entitled, "Staff Data on H.R. 1: Analysis of Cost of Committee Bill." In addition to summary cost data on Social Security cash benefits, medicare, medicaid and aid for the aged, blind, and disabled, the print contains extensive material on different estimates of cost for the family programs in H.R. 1 and the Finance Committee's AFDC and workfare alternative.

The Department recognizes that when new programs are presented, there will be reasonable differences among various estimates of program cost and impact. However, the Department believes that the material on the family programs in the committee print is presented in a manner which distorts and overstates the actual differences in the

estimates. Further, it believes that the Administration's cost estimates of both its own welfare reform proposals and of the committee's alternative are reasonable and conservative. It believes these estimates to be more realistic than those prepared by the committee's consultant, Mr. Robert J. Myers who is a former chief actuary of the Social Security Administration.

According to Mr. Myers, the Administration's estimates of the costs of H.R. 1 family programs is too low; the Administration estimate of the cost of committee proposals is said to be too high. The basis for the Department's reiteration of support for the Administration estimates is discussed below.

B. H.R. 1 FAMILY PROGRAMS

In his memo to Chairman Long, Mr. Myers states that the Department estimates the gross costs of the family programs in H.R. 1 to be \$8.4 billion. His own estimate is put at \$10.4 billion, a difference of \$2.0 billion. Actually, as reflected on page 48 of the June 12 print, the HEW estimate was \$8.5 billion. Committee decisions subsequent to April 26, the date of the Administration cost estimates, make it necessary to include several additional cost items to achieve accurate comparison of the two proposals; in particular, we now include the public service job component (omitted earlier since the Finance Committee staff had suggested the possibility of a similar plan) and the full child care allotment (since the Finance Committee has now set an authorization limit for child care). The H.R. 1 costs, on a fiscal year 1974 base adjusted for a full year of all programs, is as follows:

H.R. 1 (fiscal year 1974 Base)

	Dollars in billions
A. Payments to families:	
A1: Fiscal year 1974 with one-half year of working poor.	\$6.1
A2: Adjusted for full year of working poor.....	6.4
A3: Full year off-set for public service jobs.....	- .4
A4: Full year net payments.....	6.0
B. Hold harmless payments attributable to family program ¹.....	.6
C. Public service jobs.....	.8
D. Child care.....	.8
E. Services and training.....	.6
F. Administration.....	.7
G. Impact on other programs.....	- .1
Total.....	9.4

¹ Of a total "hold harmless" payment estimated to be \$1.3 billion in fiscal year 1974, the Federal amount attributable to refinancing the \$2,400 base in the family program, assuming States increase their supplement by an amount equal to the cash bonus value of food stamps, is \$.6 billion. (The remaining .7 is due to adult category changes.)

This \$9.4 billion estimate corresponds to suggestions by Mr. Myers on page 20 of the June 12 print. Mr. Myers is mistaken in his assertion

that our original \$6.4 billion estimate for family benefits did not include a full year of the working poor. His suggestion to add \$1.2 billion to H.R. 1 costs without detail on the vague grounds "of not recognizing . . . incentives to go onto and remain on . . . the program" must be totally rejected; in order to maintain our conservative bias, the Administration estimates assumed 100 percent of eligibles come onto the program and showed no reduction due to the work provisions of H.R. 1.

Before discussing the difference in estimates of the Senate Finance Committee plan, it is perhaps well to respond to some of Mr. Myers criticisms of the reliability of Administration cost estimating procedures. Following are the basic points:

1. *Adequacy and validity of the sample on which the estimates are based.*—The sample is the 50,000 household Current Population Survey (CPS) which is conducted monthly by the United States Bureau of the Census. The particular survey used by the Administration for its current estimates was conducted in March 1971, and reports income for 1970. The CPS is widely used by both government and private agencies and is a respected analytic and research tool.

2. *Reliance on electronic data processing equipment.*—The use of electronic computer to assist in the manipulation of large amounts of data is, of course, a well established and accepted analytic technique. The Social Security Administration, which prepares the basic estimates, employs an extensive review procedure to assure that instructions to the computer are logical and appropriate and are translated into the correct computer language.

3. *Constantly changing cost estimates.*—The Administration has published two different estimates of the costs of H.R. 1. The first was prepared in May 1971, when the House of Representatives was considering the bill. The second was prepared at the Finance Committee's request in February 1972. The latter estimate relies on more current data from the Bureau of Census, more recent projections of current welfare program costs from the States, and incorporated the later effective dates requested by the President.

4. *The projected costs of family payments decline in future years.*—It is a matter of simple arithmetic that, if benefit levels remain constant and the income of the working poor continues to increase as it has in the past, this increase will more than offset any population increases. Smaller and smaller payments would be made to recipients until eventually there would be no payments at all. H.R. 1 estimates assume normal economic and population growth and therefore reflect this fact.

Despite his criticisms in these and other areas, Mr. Myers apparently accepts the basic Administration estimating methodology since he bases his revisions in the estimates solely on the assumption that potential recipients will alter their present behavior in a way which will increase costs.

C. FINANCE COMMITTEE FAMILY PROGRAM ALTERNATIVE

Mr. Myers presents the Administration cost estimates, which were published on April 26 on the basis of a Finance Committee print, as though they would not be revised on the basis of subsequent committee

actions. This produces a difference in estimated costs of \$75 billion, obviously an exaggeration of the true difference.

The following table is a more accurate portrayal of Administration and Myers' estimates. Administration figures as presented here differ from earlier ones only on the basis of committee decisions which have revised or clarified the program as it was initially proposed in April. For example, the children's allowance, suggested by the committee staff, was not accepted by the committee itself and the costs are not included below. A discussion of each item follows the table.

	HEW estimate	Myers estimate
Government employment.....	\$4.1	\$2.6
Wage supplement.....	1.9	.3
10 percent work bonus ²	1.1	1.2
Welfare payments.....	3.7	3.7
Cost of cashing out food stamps.....	1.8	1.8
Child care.....	.8	.8
Services, training.....	.7	.4
Administration.....	1.3	.7
Federal programs.....	(.7)	(.4)
State programs.....	(.6)	(.2)
Impact on other programs.....	-.1	
Total ¹	15.3	11.5
Difference: HEW-Myers.....		3.8

¹ The fiscal relief provisions and the \$20 and \$50 disregards have not been spelled out clearly enough to determine how much additional Federal cost would result.

² The HEW and Myers estimates were both based on an earlier description of the work bonus program, which was subsequently modified somewhat.]

D. GOVERNMENT EMPLOYMENT

Administration figures originally assumed that 1.9 million persons including 600,000 family heads who would quit other jobs, would participate in the employment corporation at an annual cost of \$3,000 a year. The committee has since decided that, if the minimum wage were to rise to \$2.00 per hour as the Administration had assumed, the employment corporation would offer only 32 hours at \$1.50 per hour. This would keep the maximum annual earnings at \$2,400 or what it would be now at year around work at 75% of the current minimum wage. This change in maximum annual earnings alone would reduce Administration cost estimates by \$1.1 billion.

In addition, the lower annual income would undoubtedly produce fewer persons who would quit to take the guaranteed jobs. We would now assume that only 400,000 such persons would volunteer, making

the revised Administration cost estimates \$4.1 billion. As has been previously detailed, the 600,000 was conservatively estimated; especially in view of the total disregard by corporation of outside earnings, a family head would make a poor economic decision if he did not quit his private job to work for the corporation.

The Myers estimate of lower costs is predicated on the assumption of (1) many more placements in non-corporation employment (he apparently assumes no placements under H.R. 1); and (2) far fewer volunteers.

It is both the vice and the virtue of guaranteed employment programs that they must provide employment to all eligible persons who seek it. The Administration believes it is unrealistic to assume that only 100,000 family heads will find the government employment jobs more desirable than their present private employment. This is especially so in the light of the committee decision that the employment corporation will offer part-time work to those working full-time in private employment and continue to offer full-time work in the corporation to those working part-time in private employment. Because of this part of the committee proposal, not only would some people quit their present jobs but many others will seek part-time employment from the corporation to supplement their regular earnings. Mr. Myers does not explain why these poor families would not try to maximize their economic well-being.

The propensity to quit present jobs or to seek part-time employment would be greatly increased, if (as suggested in committee print #27) the committee required the States to pay supplemental benefits to families participating in the employment program.

E. WAGE SUPPLEMENT

It is around this aspect of the Finance Committee proposal, that the Administration would most expect reasonable differences in estimates. Analysis have found it difficult to estimate the cost of wage supplements or subsidies. An accurate estimate requires knowledge about the number of family heads who work at jobs paying less than the minimum wage and the amount of hours they work at such jobs.

Because there is no known data source which provides such information, the Administration adopted a crude and conservative estimating technique. It assumes that the population of family heads who have work experience and who would be eligible under H.R. 1 criteria approximates the population which would be eligible for wage supplements. This is necessarily an under-estimate since H.R. 1 eligibility is based on the earned and unearned income of all family members whereas eligibility for wage supplement depends solely on wage rates. There are many family heads who would be eligible for wage supplements as proposed by the committee but who would not be eligible for assistance payments under H.R. 1.

The Administration estimates do not assume, as the Myers material indicates, that all 2.4 million family heads with work experience would be eligible for wage supplements. The estimate is merely a calculation of the amount necessary to raise the aggregate income of these families by 75% of the difference of what they actually earned and what they would have earned if their wage rate were at least \$2.00 an hour. Since some family heads earn more than \$2.00 per hour, the actual wage subsidy (rather than the estimated) is likely to be a larger amount to a smaller number of workers.

Administration estimates do not reflect the committee decision that persons working for wages less than 75% of the minimum wage would not be eligible for the wage supplement. As Mr. Myers points out, it is unlikely, under such rules, that many, if any, family heads would hold such jobs.

On the basis of social security earnings data, which contain no information with respect to wage rate, hours worked, or family status, Myers estimates that 1.0 million workers will be eligible for the supplement. This seems very low when it is realized that there were nearly two million families in 1970 where total family income (including unearned public assistance, and earnings of all family members) was less than what it would have been if the family head had earned \$2.00 per hour for the hours he actually worked. Of these families, about 1.2 million of the family heads could not have earned more than \$1.50 per hour. The estimate also seems small in the light of the at least 23 million workers in industries where hourly earnings averaged around \$2.00 per hour in 1970. (Any such average must include numbers of persons at much lower rates.)

We continue to use this estimating methodology; adjusted for the reduced estimate of persons leaving private jobs to enter corporation work, we would raise the \$1.7 billion to \$1.9 billion.

F. WELFARE PAYMENTS

The initial Administration estimates of \$3.2 billion were based on the tentative and incomplete material contained in the April print. The estimate of \$3.7 billion, shown above in both the HEW and Myers column was developed by committee staff on the basis of subsequent committee decisions. The estimate of Federal cost appears to be reasonable.

G. COST OF CASHING OUT FOOD STAMPS

There is no disagreement on the cost at this provision, although latest estimates of average food stamp bonus show a bonus closer to \$500 per person; this would increase the estimate of the committee cashout provision from \$1.8 billion to \$2.3 billion.

H. CHILD CARE

The committee has decided that there will be an \$800 million authorization for child care. This figure is shown for both the Myers and HEW estimates.

The Department does not believe that \$800 million could buy adequate child care for the 2.1 million children aged 6 through 11 whose mothers would be ineligible for welfare, since this would be only \$380 per child per year. (Mr. Myers assumes that there will be slightly fewer children although the departmental estimates are based on the actual patterns in AFDC.)

I. SERVICES, TRAINING

Administration figures are revised downward by \$100 million to reflect the reduced estimate of volunteers for the employment corporation. However, the Department continues to believe that it is unrealistic to assume that only minimal services and training costs would be necessary under the employment program recommended by the committee.

J. ADMINISTRATION

Earlier estimates of the cost of administration were based on: (1) higher estimates of benefit payments, and (2) an assumption that the States would administer the entire food stamp "cash out" program. Departmental estimates shown above retain the assumption that the Federal costs would be 10% of total benefit payments. These are:

	Billion
Government employment.....	\$4.1
Wage supplements.....	1.9
Food stamp cash out for working poor and "employable" welfare recipients.....	1.0
Total.....	<u>7.0</u>

As we pointed out previously, we feel this underestimates the true administrative costs, since we estimate a 10% cost for only the function of distribution of benefits (including establishing eligibility, maintaining eligibility files, and paying the benefit); we do not include costs of supervision, placement, training and other "service" costs in the Corporation. Since the residual AFDC program would be about 60% of its former size, and fiscal year 1974 administrative costs under AFDC are estimated at \$1.0 billion, it is assumed that the cost of administration would be \$600 million. We feel that this is a conservative estimate, since reducing the benefit payments by 40% will undoubtedly not reduce administrative costs by 40% due to a certain fixed cost of administration. (Myers estimates a cost of \$200 million or 4.4% of benefit payments.)

K. CONCLUSION

As a result of changes in the Finance Committee approach since April 26, we can revise our estimate of the Finance Committee plan to \$15.3 billion (compared to Mr. Myers' estimate of \$11.5 billion). The comparable full-year cost of H.R. 1 is \$9.4 billion, so that as of June 27, before any additional changes by the committee, the Finance Committee version would cost \$5.9 billion more than Title IV of H.R. 1.

4. Comments of Robert J. Myers on Material Prepared by Department of Health, Education, and Welfare in Response to Myers Memorandum

In summary, I am still convinced of the validity of my estimates for the Family Assistance Plan contained in H.R. 1 as it passed the House of Representatives and for the Workfare proposal of the Senate Finance Committee. Equally, I continue to be convinced that the original DHEW estimates for these two proposals were greatly inconsistent, being biased upward as to the cost of Workfare relative to FAP. The latest HEW estimates (in the June 27 memo) remove some of this inconsistency, but by no means all. Quite naturally, I recognize the inherent possible variability in any estimates for new programs such as these, regardless of who makes the estimates.

Let me now give detailed comments on the DHEW memorandum :

(1) *Item B, first paragraph.*—The DHEW memorandum makes the quibbling comment that I stated the DHEW estimate of FAP and related programs for children in H.R. 1 to be \$8.4 billion, whereas the actual figure was \$8.5 billion. Actually, the former figure was an adjusted one, to yield comparability and consistency, and is fully explained in item B of my memorandum.

(2) *Item B, first paragraph following the table.*—At one point, the DHEW memorandum criticizes my statement of the DHEW estimate of the FAP cost of \$5.8 billion in FY 1974 as including only ½ year of payments to the working poor, whereas DHEW asserts that a full year of such payments was included. The basis for my statement is footnote 2 in the attached table ¹ (which table was the basis for my \$5.8 billion figure and was prepared by DHEW). More importantly, it may be noted that the revised DHEW figure of \$9.4 billion for FAP and related programs for children in H.R. 1, (as shown on the table in item B), when increased by my \$1.2 billion estimate of the effect of the incentives to utilize FAP, is adjusted to \$10.6 billion, or quite close to my estimate of \$10.4 billion (see last paragraph of item B of my memorandum). Thus the only significant difference between the

¹ See pp. 581-2.

DHEW estimate and mine is the extent of recognition of such incentives to utilize FAP once it were in existence.

I continue to believe—as I did when at DHEW and as my estimates of such higher costs were submitted to the House Ways and Means Committee—that this factor will occur (as it did for other legislated programs, such as Medicare and Medicaid). DHEW simply will not recognize that many persons who appear to be not eligible according to the data in the survey will make themselves eligible if the plan went into effect, by changing their income patterns.

(3) *Item B, paragraph 1.*—As to the adequacy and validity of the sample data, it may merely be pointed out that they grossly understate welfare payments as against the *known* national total. Income reporting in the CPS, especially for those at the lower-income levels, is exceptionally poor.

(4) *Item B, paragraph 2.*—As to reliance on EDP methods, EDP is without rival when it comes to recording mass data (e.g. the Social Security wage records), but it is by no means perfect when it comes to making estimates of an occasional nature that cannot be verified by parallel “hand” computations or by “human inspection” of the detailed data, in lieu of blind acceptance of the aggregate results that come out of the EDP machine at the end of the process.

(5) *Item B, paragraph 4.*—My point, which DHEW apparently failed to understand, was that it is unrealistic (and poor estimating technique too) to assume that, under conditions of dynamic economic conditions (rising prices and wages), benefit amounts would remain unchanged. Either constant economic conditions and constant benefits should have been assumed (preferably), or dynamic economic conditions and rising benefits should have been used.

(6) *Item C, first paragraph.*—A “difference in estimated costs of \$75 billion”? Why did not DHEW prepare a later estimate than the April 26 one? In any event, I did recognize that the plan had been changed somewhat since DHEW had made its estimate (see item C-1 of my memorandum; also excluded there was \$.5 billion estimated by DHEW for a children’s allowance program that was originally considered, but was not in the proposal for which I made a cost estimate).

(7) *Item C, table.*—The revised DHEW estimate for the Committee proposal—revised both as to methodology and to reflect changes in provisions—is now much closer to my estimate, but I believe that my estimate is still valid and is closer to the likely results that would be experienced. I recognize, of course, that completely accurate estimates cannot be made for any new, different program as this, without a good likelihood of some variation between estimate and actual experience. Hereafter, I shall discuss the several items on which the DHEW estimates and mine differ significantly.

(8) *Item D.*—With regard to the estimates for the Guaranteed Job Opportunity portion of the Workfare proposal, DHEW has lowered

its estimates to take into account the lower maximum wage in the Work Administration (WA) than previously, from \$3,000 to \$2,400 per year—and a small reduction in the estimate of the number who would leave private employment to go with the WA (from 600,000 to 400,000). I believe that the DHEW estimate of the latter is still far too high (for reasons given in item C-1 of my memorandum). DHEW does not take into account, as properly should be done, the elements that not all persons in the WA will work the maximum possible time and that substantial numbers will leave WA employment to work in private industry or “regular” WA employment (see item C-1 in my memorandum).

DHEW seems to believe that all persons in poor families will seek to “maximize their economic well-being” by working as much as possible. I do not believe that is so in many cases, because some will feel that the additional work relative to the additional income is not worthwhile (e.g. to work sufficient to earn \$3, but to be able to retain only \$1 of it).

(9) *Item E.*—With regard to the estimates for the Low-Wage Supplement portion of the Workfare program, DHEW has actually increased its estimate (from \$1.7 to \$1.9 billion), despite the fact that the original estimate was grossly—and obviously—overstated due to an error in the assumptions (actually, by making an assumption that could not possibly be true)—(see item C-2 in my memorandum). The increase is due to DHEW’s *lower* estimate of the number of employees who would leave private employment to go with the WA (and thus a *higher* number would remain in low-paid private employment). It seems incredible that DHEW would continue to use the obviously impossible assumption that the *average wage supplement* would be as much as \$.68 per hour, when the *absolute maximum possible for any individual case* is \$.38 (so that the average would likely actually be only about \$.20)—(see item C-2 of my memorandum.)

The DHEW estimate of the number of eligible workers is too high, because it uses 1970 data without adjusting for the effect of increasing general wage levels between then and FY 1974, to which the estimates are intended to relate. I believe that my estimate in the previous memorandum continues to be reasonable, despite the new DHEW estimate and the DHEW criticism.

It may be noted that using the DHEW cost estimate of \$1.9 billion for FY 1974 and an average work-week of 27 hours as DHEW has assumed, plus an average hourly wage supplement of \$.20 (see above), there is thereby implied an average number of eligible workers of 5.3 million (\$1.7 billion divided by 52 times 27 times \$.20). This is obviously ridiculously high.

(10) *Item I.*—As to the cost estimate for services and training, the DHEW estimate is slightly reduced (from \$.8 billion to \$.7 billion), but is still well above my estimate (\$.4 billion). For the reasons given

in item C-6 of my memorandum, I continue to believe that my estimate is reasonable.

(11) *Item J.*—As to the cost estimate for administrative expenses, DHEW has reduced its estimate for \$1.7 billion to \$1.3 billion—as compared with my estimate of \$.7 billion. The difference between the estimates for the Federal programs (\$.7 billion vs \$.4 billion) is entirely due to the differing estimates of benefit payments, since the estimates of administrative costs are based on a percentage thereof. The difference between the estimates of Federal payment of the administrative expenses for the State programs (\$.6 billion vs \$.2 billion) is not so readily explained; my estimate may be a bit low, but the DHEW estimate seems too high for reasons that I have given in item C-7 of my memorandum (in any event, any change in my estimate would be small relative to the estimate for the total program).

In summary then, I believe that my previous cost estimates for the Family Assistance Plan and related proposals for children as contained in the House-passed version of H.R. 1 and for the Workfare proposal were good estimates, despite the DHEW criticisms in its memorandum of June 27. Similarly, I believe that the revised DHEW estimates contained in that memorandum are too low as to the former and too high as to the latter (although these estimates are improvements over earlier DHEW estimates, in some respects).

[ATTACHMENT 3]

POTENTIAL FISCAL YEAR 1974 COSTS OF ASSISTANCE PROVISIONS UNDER H.R. 1

[In billions of dollars]

	Federal			State and local ¹			Net cost to all Governments
	Current law	H.R. 1	Net cost	Current law	H.R. 1	Net cost	
Payments to families	\$4.8	² \$6.1	\$1.3	\$3.9	\$3.2	\$0.7	\$0.6
Less savings from public service jobs		-.3	-.3				-.3
Subtotal	4.8	5.8	1.0	3.9	3.2	-.7	.3
Payments to adult categories	2.2	4.1	1.9	1.5	1.6	.1	2.0
Cost of cash assistance	7.0	9.9	2.9	5.4	4.8	-.6	2.3
Federal cost of "hold harmless" provision		1.3	1.3		-1.3	-1.3	
Food programs	2.4	1.0	-1.4				-1.4
Cost of maintenance payments	9.4	12.2	2.8	5.4	3.5	-1.9	.9
Child care .....	.3	.8	.5				.5
Training .....	.2	.5	.3				.3
Public service jobs .....		.8	.8				.8
Supportive services .....		.1	.1				.1
Administration .....	.4	1.1	.7	.4		-.4	.3

Cost of related and support activities.....	.9	3.3	2.4	.4	.....	-.4	2.0
Total cost of program.....	10.3	15.5	5.2	5.9	3.5	-2.3	2.9
Impact on other programs.....		-.1	-.1	.....	.....	.....	-.1
Grand total.....	10.3	15.4	5.1	5.9	3.5	-2.3	2.8

¹ Assumes that the States, through supplemental programs, maintain benefit levels including value of food stamp bonuses.

² Includes only 6 months of payments to families in

which both parents are present, neither is incapacitated, and the father is employed. The effective date for this provision is Jan. 1, 1974.

³ See page 576, item 2.

XIII. INTERNAL REVENUE CODE AMENDMENTS

(583)

Internal Revenue Code Amendments

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XIII. INTERNAL REVENUE CODE AMENDMENTS

Retirement Income Credit

(Sec. 531 of the bill and sec. 37 of the code)

1. 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).

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 broad 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.

The committee agrees with the House 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.¹ 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

¹ 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.

the maximum social security primary benefit of slightly 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 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 return, a taxpayer must show that he has met the test of earning \$600 a year for 10 years; he must also segregate his retirement income from his other 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, but receive retirement income, 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 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 this credit on their tax returns.

The House also modified the present retirement income credit to make it available in some cases to persons with earned income. The committee believes, however, that this removes one of the important objectives of the present retirement income credit; namely, to roughly equate individuals who receive little or no social security tax benefits, but receive retirement income, with individuals who receive the maximum amount of social security benefits. As a result, the committee amendments do not make the credit available for earned income. In other words, the committee bill, in contrast to the House bill, retains the provision of present law that bases the credit on the amount of retirement income.

To deal with the problems described above, the committee agrees with the House's decision to update the amount on which the credit is based and to revise upward the earnings limitations. The committee also agrees that the problem of complexity should be dealt with 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, 10-year earnings test has been eliminated. In addition, the variation in treatment of married couples depending on whether they

are separately eligible for credits is eliminated. However, the committee amendments, as under present law, limit the credit to the amount of retirement income.

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 maximum amounts for computing the credit are reduced, as under present law, by social security benefits and other exempt pension income.

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.

These reductions of the maximum amount for social security and earnings determine the amount of retirement income eligible for the credit. The credit is determined by simply multiplying the lesser of the retirement income or the maximum amount (after any of the reductions referred to above) by 15 percent.

Based upon 1972 exemption levels a single individual age 65 who receives the maximum retirement income credit could receive up to \$4,321 before paying any income tax under present law if the income is exclusively from pension or retirement income sources. Under the revised credit, he may receive up to \$5,142 of income and still pay no tax again if the income is exclusively from pension or retirement income sources.

Under present law a married couple filing a joint return where both are age 65 or over may receive \$6,631 of pension or investment income before paying any tax.¹ Under the revised credit, they could receive up to \$7,962 of pension or investment income before paying any tax. Moreover, the revised 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.²

There will be a few rare instances in which a higher tax than under present law may result from the revised credit. These cases arise where one spouse has pension or investment income and is eligible for the credit under present law, the other spouse has earned income and a joint return is filed. 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. The committee agrees with the House con-

¹ Assuming the alternative retirement income credit computation based on \$2,286.

² If each spouse has at least \$2,000 of earnings, the maximum amount 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.

clusion, 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 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 \$2,400 for each spouse and by phasing out the amount on which the credit is based for earned income above \$2,400 on a 50 cents per dollar basis rather than on the dollar-for-dollar basis provided by present law.

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 about 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 social security benefits and certain other tax-exempt income. It also requires the taxpayer to deduct earned income above specified levels. The credit is computed at a 15 percent rate on the lesser of the amount of the retirement income or the balance, and this is then entered on the tax return as a tax credit.¹

¹ 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 technical discussion.

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		<i>Then your maximum amount for credit computation is—</i>
If you are: (check one box)		
<input type="checkbox"/>	Single.....	\$2, 500
<input type="checkbox"/>	Married filing jointly and only one spouse is 65 or over.....	2, 500
<input type="checkbox"/>	Married filing jointly, both age 65 or over.....	3, 750
<input type="checkbox"/>	Married filing a separate return and age 65 or over.....	1, 875
<hr/>		
1.	Enter (from above) your maximum amount for credit computation.....	
2.	Amounts received as pensions or annuities under the Social Security Act, the Railroad Retirement Acts (but not supplemental annuities) and certain other exclusions from gross income.....	
3.	Earned income received (does not apply to persons age 72 and over). Enter ½ of earnings over— \$2,000 if single; \$2,000 received by the husband _____, plus \$2,000 received by the wife _____, if married and filing jointly; or \$1,000 if married and filing separately.....	
4.	Total of lines 2 and 3.....	
5.	Balance (subtract line 4 from line 1); if more than zero complete this form; if zero or less, do not file this form.....	
6.	Amount of retirement income.....	
7.	Amount of credit; enter (here and on form 1040, line 52) 15 percent of lesser of line 5 or line 6 but not more than the total tax on form 1040, line 19.....	

Those under 65 receiving pensions from public retirement systems.— Under present law, individuals under the age of 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 qualifies 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 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 by reason 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 now 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, the committee agrees with the House decision to make 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 revised 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. (These amounts are \$500 and \$1,000 respectively in the case of a married person filing a separate return.)

The principles and method of computation of the credit are essentially the same as present law. Like the revised credit for those 65 and over, however, the revised retirement income credit requires that the earnings of both spouses be combined in the case of a joint return; the separate computation of present law is eliminated.¹

The committee agrees with the House conclusion 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 reduce tax liability in calendar year 1973 by \$225 million.

Effective date.—The House bill would have made the changes proposed in its version of the bill effective for the calendar year 1972 and later years. In order to avoid retroactive effect, the committee has postponed the effective date by one year. As a result, the provisions are to first apply to taxable years beginning after December 31, 1972.

2. Technical discussion

Individuals 65 years of age and over.—In general, the credit provided by the bill as amended by the committee (sec. 37 of the code) liberalizes the retirement income credit available under present law for those age 65 and over in three respects. First, the amount of retirement 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, 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. Third, the credit is to be available regardless of whether the individual has had work experience (i.e., has received earned income) in 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.)

As indicated above, the committee has retained the concept of present law that the amount of the credit is based upon the amount of retirement income. For this purpose, retirement income, as under present law, is defined to mean income from pensions and annuities (including, as is the case under present law, public retirement system

¹ 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 with a spouse receiving public pension income could, in effect, receive a larger maximum credit than a taxpayer age 65 whose spouse did not receive such pension income.

pension income), interest, rents, and dividends. As under existing law, there is a limit on the amount of retirement income which may be taken into account.

Under the bill the amount of retirement income with respect to which the 15-percent credit may be claimed may not exceed \$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 10 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 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 which 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 of retirement income 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 pension 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 of retirement income 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 of retirement income is \$3,750.

As in the case of those 65 years of age and over, the maximum amount of retirement income 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 of retirement income 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 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.

The bill limits the amount which may be taken into account for purposes of the credit in the case of individuals under age 65 to public retirement system pension income. However, in no event may more than \$2,500 of this income received by an individual during a taxable year be taken into account. 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 would cause a reduction in their \$3,750 maximum amount of retirement income which may be taken into account. If one spouse received a \$3,000 public retirement system pension while the other spouse received only a \$100 public retirement system pension, they could take into account \$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 of retirement income 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 pension, the bill provides that a further reduction in the maximum amount of retirement income 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, since the bill makes no specific provision for a refund in this case, the credit may not exceed the individual's (or the married couple's, in the case of a joint return) tax for the year. For this purpose, however, the bill provides that the credit 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. The House bill 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. The committee agrees with the House decision and further believes that the rule should apply to all income derived from personal effort. Accordingly, the committee has amended the House bill to further provide that the community property laws are not to be taken into account in determining whether income from pensions and annuities for personal services (including public retirement income pensions) is the income of the husband or wife. Accordingly, in a community property State, earned income, or pension income, received by the husband for personal services performed by him is to be considered entirely his income and not in part attributable to his wife.

In addition, as under present law, nonresident aliens are not to be eligible for the credit provided by the bill.

The amendments made by the committee's version of the bill with respect to the retirement income credit are to apply to years beginning after December 31, 1972. The House bill would have applied to years beginning after December 31, 1971.

Earlier in the report, an illustrative schedule for the credit in the case of those 65 and over was shown. The schedule which follows indi-

cates how the tax credit can be computed separately for those under age 65 who have public retirement system pensions.

SCHEDULE S.—Credit where at least one taxpayer is under age 65 and receives pension or annuity income from public retirement systems

<i>If you are (check one box):</i>	<i>Then your maximum amount for credit computation is—</i>
<input type="checkbox"/> Single under 65 and receiving public retirement pension.....	\$2, 500
<input type="checkbox"/> Married filing jointly both under 65 and one receiving public retirement pension.....	2, 500
<input type="checkbox"/> Married filing jointly both under 65 and both receiving public retirement pension.....	3, 750
<input type="checkbox"/> Married filing jointly, one under 65 and receiving public retirement pension and other spouse over 65.....	3, 750
<input type="checkbox"/> Married filing separately under age 65 and receiving public retirement pension.....	1, 875

1. Enter (from above) your maximum amount for credit computation. _____
2. Amounts received as pensions or annuities under the Social Security Act, the Railroad Retirement Acts (but not supplemental annuities) and certain other exclusions from gross income. _____
3. Earned income received (does not apply to persons age 72 or over):
 - Single: age 62 or over, enter ½ of earnings over \$2,000; under age 62, enter all earnings over \$1,000.....
 - Married filing jointly: enter ½ of earnings in excess of \$2,000 for each spouse age 62 or over; and all earnings over \$1,000 for each spouse under age 62.....
 - Married filing separately: age 62 or over, enter ½ of earnings in excess of \$1,000; under age 62, enter earnings in excess of \$500.....
4. Total of lines 2 and 3. _____
5. Balance (subtract line 4 from line 1); if more than zero complete this form; if zero or less, do not file this form. _____
6. Income received by taxpayers under age 65 from pensions and annuities under public retirement systems (e.g., Federal, State Governments, etc.) included on form 1040, line 18. But no more than \$2,500 for each spouse for married filing jointly. _____
7. If married filing jointly, and one spouse is age 65 or over and the other spouse has public pension income, subtract the amount of such income from \$1,250 and enter difference (not less than zero). _____
8. Subtract line 7 from line 5 and enter remainder. _____
9. Enter the smallest of lines 5, 6, or line 8. _____
10. Amount of credit: enter (here and on form 1040, line 52) 15 percent of line 9 but not more than the total tax on form 1040, line 19. _____

Tax Credit for Employing Welfare Recipients

(Sec. 532 of the bill and sec. 50B of the code)

Present law.—Under present law, in certain cases an employer is allowed an income tax credit equal to 20 percent of the wages he pays to an employee during the first 12 months of his employment (whether or not these are consecutive months). However, the aggregate amount of any such credits which may be taken in any year may not exceed the tax liability (before this credit) in the case of the first \$25,000 of

liability plus 50 percent of this tax liability over \$25,000. However, a carryback of 3 years (but not before 1972) and a carryforward of 7 years are allowed with respect to any such unused amounts. The principal conditions which must be met for this credit to be available are:

1. The credit is available only for an employee employed in a trade or business of the taxpayer.
2. The employee must be an individual certified by the Secretary of Labor as having been placed in employment under a Work Incentive (WIN) Program (established under section 432(b)(1) of the Social Security Act).
3. The individual must be continued in employment for at least 1 year after the completion of the first 12 months of employment unless the employee becomes disabled, or ceases his employment either voluntarily or because of misconduct. (If a credit is taken but this 2-year employment rule is not met, the credit is subject to a recapture rule.)

In addition to the WIN tax credit, elsewhere in the tax laws (sec. 214) a deduction is allowed for household service and dependent care expenses incurred in order to permit the taxpayer to be gainfully employed. The maximum deduction is \$400 per month but is phased out (on a 50 cents per dollar basis) when the adjusted gross income of the taxpayer exceeds \$18,000.

Reasons for change.—The committee believes that it is highly desirable to encourage not only businesses but also private individuals to hire individuals who would otherwise be on public assistance rolls. This reflects the committee's interest in developing job opportunities for welfare recipients wherever possible in regular jobs. Encouraging individuals to work is good not only from the standpoint of their own self-esteem, but is also advantageous to the government in that it relieves the government of substantial welfare costs.

The two tax provisions referred to above, the WIN tax credit and the deduction for household service and dependent care expenses, already accomplish the objectives sought by the committee in part. The WIN tax credit, however, is limited to those employed in a trade or business and, therefore, does not encourage the employment of individuals to perform nonbusiness personal services. In addition, the committee bill replaces the present WIN program with an entirely new guaranteed employment program, with its primary aim the placement of employable persons who are now welfare recipients in regular employment.

In view of this, the committee has added a provision to the bill extending the application of the present work incentive credit to cover nonbusiness as well as business employees. In addition, because the WIN program will be phased out under the bill, the provision will cover business employees certified under the Guaranteed Employment Program by the Work Administration. In this connection, the name of the credit is also changed to the guaranteed employment credit.

To be sure that the primary emphasis is placed on the hiring of bona fide participants in the guaranteed employment program, the credit of 20 percent is provided only for persons who have been participating in the program at least one month, and the credit applies with respect to wages paid up to \$4,000. To make sure that the credit given with

respect to nonbusiness employees does not provide a double tax benefit (when taken into account with the deduction for household service and dependent care expenses), the credit is not to be allowed in any year in which the household service and dependent care expense deduction is claimed.

This credit, to the extent that it achieves its objective of obtaining greater employment through the private sector of the economy, will also have the effect of significantly reducing government costs, since the cost of the guaranteed employment which ends upon entry into private employment substantially more than offsets the cost of any credit allowed under this provision. For example, the credit per employee may result in a revenue reduction of as much as \$800 but may save the government up to \$4,800 in wages under the guaranteed employment program over the two-year period.

Explanation of provision.—The credit for the nonbusiness employees and for business employees whose employment begins after 1973 will be based on the employee's annual wage rate or \$4,000, whichever is smaller. With the credit being at a 20-percent rate, this limits to \$800 the amount of credit which may be obtained with respect to any one employee. The annual rate, as used here, means compensation paid for at least three-fourths of the normal employment period. As a result, if an employee is paid \$4,000 per annum, but works less than three-fourths of the normal employment period, the maximum credit would be reduced commensurately. This limitation does not apply in the case of those qualifying under the WIN program who are employed before December 31, 1973.

A second limitation provides specifically that in the case of non-business employees and business employees hired after 1973 the credit is not to apply with respect to more than 15 percent of the aggregate wages paid (or incurred) by the employer to all employees during the year. For purposes of this test, only so much of the aggregate wages paid (or incurred) which do not exceed (for each employee) the average rate of the wages paid the employees certified under this provision are to be taken into account. Generally, this will have the effect of taking into account the first \$4,000 of wages paid to all employees in determining whether or not the 15 percent test is met.

An exception to the 15 percent test, however, provides that the employer may always take the full credit with respect to wages paid to at least one employee even though this exceeds the amount specified under the 15 percent rule. The limitations described here apply separately in the case of business and nonbusiness employees of an individual. Married taxpayers, whether filing a separate or joint return, are to be entitled to a credit for only one nonbusiness employee unless they qualify for additional credits under the 15 percent rule. Where they file separate returns, they are to be required to choose, in a manner to be prescribed by regulations, which of them is to receive the credit.

Taxpayers electing to receive the credit are not to be eligible in the same year to take a deduction for expenses for household and dependent care service, (sec. 214). As a result, the provision specifies that for the credit to be available the taxpayer must make an election (within such time and manner as may be prescribed by regulations) in order to obtain the credit.

To qualify for the new credit, nonbusiness employees and business employees hired after 1973 must be certified by the Work Administration (created by this bill) as having participated immediately before employment for at least one month in the Guaranteed Employment Program administered by the Work Administration (under the new Title XX of the Social Security Act). Also it must be certified by the Work Administration that these employees are not displacing any individual from employment. Those business employees hired under the WIN program before 1974 will continue to be certified as under present law by the Secretary of Labor.

As under present law, in all cases the employer will be required to retain an employee for at least one year after the expiration of the initial 12-month period (which need not be consecutive) in order to obtain the tax credit. Otherwise, the recapture provision of present law is to apply to any credit already claimed on the prior year's return. As under present law, exceptions to this requirement of one year additional employment are to apply in the case of employees whose employment is discontinued because of death, voluntary withdrawal from employment by the employee, or discharge for misconduct.

Revenue Effect.—Because it is difficult to evaluate the inducement to employ individuals which this provision will provide, any estimate of the revenue loss involved is at best only an approximation. Moreover, as indicated previously, any revenue cost involved should be substantially more than offset by a decrease in welfare costs to the government. As a result, it is anticipated that this provision, taking into account both the revenue loss and decrease in welfare costs, will result in a small decrease in any budget deficit which otherwise would occur.

Employees of Members of Affiliated Groups of Organizations

(Sec. 533 of the bill and secs. 3121(t) and 3306(o) of the code)

Present law.—The social security tax (FICA tax) is based on the wages paid to an employee with a limitation on the amount of wages subject to tax. Under present law, the limitation is \$9,000 (increased to \$10,800 in 1973 and \$12,000 in 1974). The Internal Revenue Service has held that where an employee on the payroll of one member of an affiliated group of corporations also performs services for other members of the same group (although not specifically on their payrolls) the FICA tax is payable on the first \$9,000 (or larger amount in later years) of wages attributed to each corporation. In such a case, the individual is treated as if he were a separate employee of each member of the group for which he performs services and, as a result, the remuneration he receives is attributed to each member of the group for which he performs the services.¹ In such a case, the total FICA tax collected with respect to an individual's employment may be based on compensation considerably in excess of the statutory limitation. In such a case, the employee may obtain a refund of any excess FICA tax paid by him, but the members of the group which are treated as his employers may not.

¹ These situations are described in Rev. Rul. 69-316 under groups 1 and 3.

Similarly, the Federal unemployment tax (FUTA tax) is based on the wages paid to an employee with a \$4,200 limitation on the wages subject to tax. This tax, which is imposed only on the employer, may also in effect be imposed on compensation in excess of the statutory limitation in cases of individuals treated as an employee by more than one member of the same affiliated group of corporations.

Reasons for change.—The committee believes that it is not desirable to impose double taxes on the employers in these cases, merely because an employee of one corporation also performs services for another corporation which is a member of the same affiliated group.

Explanation of provision.—For the reason given above, the committee has added to the bill a provision which, for purposes of the FICA and FUTA taxes, provides that an individual who performs services for more than one member of an affiliated group of corporations is to be treated as an employee only of the member of the group from which he receives his compensation. Thus, the present practice of attributing payments of compensation made by one member of an affiliated group to other members of the group for purposes of determining whether the FICA and FUTA taxes apply is no longer to be followed. The provisions of this bill do not provide a ceiling, however, where an employee is transferred from one member of an affiliated group to another member of the group and no longer performs services as an employee of the first member. Nor does the provision provide a ceiling in the case of an employee who is on the payroll of each of two (or more) affiliated corporations.

For purposes of these provisions, the term “affiliated group” means two or more corporations where there is 80 percent or more common stock ownership (as defined in section 1504(a)). For this purpose, however, any corporation is to be treated as an includible corporation. That is, for this purpose there is to be included any exempt corporation, insurance company, foreign corporation, corporation receiving most of its income from possessions, China Trade Act Corporation, regulated investment company, real estate investment trust or DISC corporation with respect to which there is the requisite 80 percent common stock ownership.

The amendments made by these provisions of the bill are to apply with respect to wages paid after December 31, 1972.

Revenue effect.—This provision is not expected to decrease tax liability by more than \$10 million for calendar year 1973.

Required Information Relating to Excess Medicare Tax Payments by Railroad Employees

(Sec. 293 of the bill and sec. 6051 of the code)

Present law.—Under present law as provided by the Social Security Amendments of 1967, a railroad employee or railroad representative whose work is covered by railroad retirement and who is also employed in other work covered by social security is entitled to receive a credit or refund of the excess medicare tax he may have paid because of this dual employment status. To inform an employee of his compensation covered by railroad retirement and the hospital tax deducted from it, the 1967 Amendments required railroads to include on the W-2 forms (which must be furnished to employees by January 31 of each year),

the amount of wages paid subject to railroad retirement, the amount of railroad retirement tax deducted from these wages, and the portion of the tax attributable to hospital insurance (medicare). With this information it was presumed that he would be aware of his refund rights and thereby claim them as a credit on his return.

Reasons for change.—Unfortunately, the present information requirement cannot readily be complied with by the railroads in time to meet the January 31 date. The railroads' inability to furnish this information by January 31 results from the fact that the wage concept under railroad retirement is different from the wage concept for Federal income tax purposes. Adjustments required in arriving at railroad retirement compensation (which is determined on a monthly basis for any year), cannot be readily made in the 31-day period following the close of the calendar year. Also, the railroads cannot identify the relatively few employees who might be eligible for refunds and thus must necessarily supply the information on the W-2 forms to all their employees, which number about 580,000.

Explanation of provision.—In view of the problem described above, the committee decided to delete the provision of present law requiring railroads to supply separate hospital tax information on the W-2 forms for their employees. This is accomplished by deleting the reference to section 3201 in section 6051(a) and by striking out paragraphs (7) and (8) in that subsection. In addition, the reference to section 3201 is deleted from section 6051(c).

In place of supplying the separate hospital tax information generally on all W-2 forms, the bill requires that railroad employers include on, or with, these forms a notification that any person who has a second employment, in addition to his railroad employment, may be eligible for a credit or refund of any excess medicare tax which he might have paid because of employment under both social security (including employee and self-employment coverage) and railroad retirement. This is provided by adding a new subsection (e)(1) to section 6051.

In addition, railroad employers, in the case of individuals having this dual railroad retirement and social security coverage, are, upon the request of the employee, to furnish him a written statement showing the amount of railroad tax coverage, the total amount deducted as tax, and the portion of the total amount which is for the financing of the cost of hospitalization insurance under part A of title XVIII of the Social Security Act.

This limits to a relatively small number the cases where the additional information needs to be supplied.

This provision is virtually identical with the provision contained in H.R. 17550 which was passed by the Senate in the last Congress. It is effective with respect to remuneration paid after December 31, 1971.

Work Bonus for Low-Income Workers

(Sec. 535 of the bill and secs. 10001, 10002, 10003, 10004, and 10005 of the code)

Present law.—Presently, no Federal income tax is paid by those with incomes at or below the poverty level. On the other hand, there are no provisions for a work bonus under present law and

welfare payments generally are reduced if the individual begins to work. For example, in the case of a welfare mother, after allowance is made for work expenses, her welfare payments are reduced \$2 for each \$3 earned in excess of \$30 per month.

Reasons for change.—Although the low income allowance eliminates income tax on those below the poverty level, the requirement that a social security tax, without the benefit of this allowance or personal exemptions, be paid by virtually any employed person still means that the existing structure contains a disincentive for employment. This social security tax burden does have the effect of diluting the value of employment, a result which the committee finds inconsistent with its overall objective of making employment more attractive than welfare. For this reason the committee believes that the requirement that individuals heading low-income families pay social security taxes if they work should not be a source of discouragement to their seeking gainful employment. To overcome any such discouragement, the committee added to the bill provisions for payment of a work bonus based on a percentage of the individual's wages up to a maximum of \$4,000. This approximates the combined social security tax taken out of his wages and paid for him by his employer.

Explanation of provision.—For the reasons given above, the committee has amended the House bill by adding a new provision to the tax laws providing that low-income workers (physically present in the United States) who head families having one or more dependent children are to receive a work bonus equal to 10 percent of their wages (up to a maximum of \$4,000) if they are subject to social security or railroad retirement taxes or, in a few cases (explained below), even if their employment is not covered by these taxes. In the case of married taxpayers, the bonus would be computed on the basis of the combined earnings of both. The bill provides a permanent appropriation to provide for these bonus payments.

The work bonus (10 percent of their wages taxed under the social security (or railroad retirement program), if the total income of husband and wife is \$4,000 or less) is to be gradually reduced where the \$4,000 total income level is exceeded. It is to be reduced by one-quarter of any income of the individual (and of the spouse in the case of a married taxpayer) over \$4,000 per year. This gradual phaseout of the work bonus above a total income level of \$4,000 minimizes any work disincentive of the provision above \$4,000. With this phaseout, there is to be no work bonus once the total income of the individual (and any spouse) reaches \$5,600.¹

In determining when an individual's "income" exceeds \$4,000 for purposes of this work bonus, "income" is defined as including all income from whatever source derived, including income which is excluded from the income tax base (for purposes of subtitle A).

The size of the work bonus is shown on the table below for selected income levels:

¹ \$5,600 exceeds \$4,000 by \$1,600, one-quarter of \$1,600 is \$400, which subtracted from the maximum bonus of \$400 equals 0.

Annual income of husband and wife (assuming it is all taxed under social security)	Work bonus
\$2,000	\$200
3,000	300
4,000	400
5,000	150
5,600	0

The work bonus, by not varying benefits by family size, but only by income, provides no economic incentive for having additional children.

As indicated previously there are some cases where the work bonus is available even though the individual is not subject to social security or railroad retirement tax. Under present law, some work ordinarily covered under social security is not covered where the wages earned from a single employer are not in excess of \$50 a quarter. For example, this rule applies to the employment of domestics, gardeners, and other similar nonbusiness employees. Under the committee amendments, employees of the Work Administration (if they otherwise qualify) are to be eligible to receive the work bonus if they perform this type of work for persons who have entered into contracts with the Work Administration for the performance of the work. In this case, the Work Administration will pay the employee the prevailing wage for the job and bill the person for whom the services were performed for the wages and other costs associated with making the individual's services available. Under other provisions of the bill, employees of the Work Administration who perform services for persons who have entered into contracts with the Work Administration will be covered under social security if the services performed would have entitled the employees to such coverage had they been performed as employees of those persons. These employees (if they otherwise qualify) will also be eligible for the work bonus since their wages will be subject to social security tax. Other employees of the Work Administration (i.e., those who do not perform services for other persons under contracts entered into with the Work Administration) will not be eligible for the work bonus.

Individuals who are eligible to receive work bonus payments may apply for advance payment of these amounts. Under this procedure, at any time after completion of the first calendar quarter, and before the expiration of the second quarter, an individual may apply for the work bonus he is entitled to receive based on earnings in the first quarter but taking account of the earnings he expects to receive in subsequent quarters. After completion of the second quarter, application may be made for an additional payment (or for an initial payment if no advance payment had been made for the first quarter). A similar procedure may be followed after completion of the third quarter, but for the fourth quarter the bonus payment is to be applied for in connection with the filing of the statement, (referred to below) after the end of the year, or claimed as a credit in the same manner as the overpayment of income tax. Applications which would be filed with the Internal Revenue Service are to be made in a manner to be prescribed under regulations.

No advance payment for any quarter is to be made to any individual who, on the basis of the income he expects to receive during the entire year, is not eligible for a bonus payment for the year. In addition, to eliminate *de minimis* claims, no advance payment of less than \$30 is to be made.

At the end of the year, the individual who has received advance payments is to file a statement with the Internal Revenue Service setting forth the amount of income which he (and his spouse) had received during the year and the amount which he (and his spouse) had received as advance payments, together with such other information as may be required by regulations. (In addition, all agencies and departments of the United States Government would be authorized and directed to cooperate with the Treasury Department in supplying information necessary to implement the work bonus program.)

If the Internal Revenue Service determines an individual has received advance payments in excess of the work bonus to which he was entitled for a year, it is to notify the individual of the amount due and collect the amount due. The excess payments may be collected by withholding from future work bonus payments which the individual otherwise is entitled to receive, by treating the excess payments as a deficiency under the tax laws, by entering into an agreement with the individual providing for repayment or by taking such other action to secure repayment as may prove necessary.

In lieu of receiving payment of a work bonus, the individual is to be allowed to elect, at a time (not later than the due date for filing income tax returns) and in a manner to be prescribed by regulations, to take the amount of the work bonus as a credit against tax.

Each document and application to be filed in connection with the work bonus program is to contain a written declaration that it was made under penalty of law. The provisions of present law relating to crimes, other offenses, and forfeitures (chap. 75) are to apply to all of these documents.

This provision is to become applicable to taxable years beginning after December 31, 1972.

Revenue effect.—It is estimated that the bonus payments and tax credits under this provision would total approximately \$900 million for calendar year 1973.

**XIV. CHANGES IN EXISTING LAW AND COMPLIANCE
WITH LEGISLATIVE REORGANIZATION ACT**

(605)

A. VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act of 1946, the tabulation of the roll call vote to report the bill is as follows:

In favor—15 (Messrs. Long, Anderson, Talmadge, Hartke, Fulbright, Ribicoff, Byrd, Jr., Nelson, Bennett, Curtis, Miller, Jordan, Fanning, Hansen, and Griffin).

B. CHANGES IN EXISTING LAW AND COMPLIANCE WITH LEGISLATIVE REORGANIZATION ACT

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown in the following pages (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman).

**EXCERPTS FROM SOCIAL SECURITY ACT, AS
AMENDED**

	Page
[Title I—Grants to States for Old-Age Assistance and Medical Assistance for the Aged] -----	610
Title II—Federal Old-Age, Survivors, and Disability Insurance Benefits -----	621
Title IV—Grants to States for Aid and Services to Needy Families with Children and for Child Welfare Services -----	
Title V—Maternal and Child Health and Crippled Children's Services -----	
[Title X—Grants to States for Aid to the Blind] -----	
Title XI—General Provisions and Professional Standard Review -----	
[Title XIV—Grants to States for Aid to the Permanently and Totally Disabled] -----	
Title XV—Grants to States for Care and Treatment of Drug Addicts and Alcoholics -----	
Title XVI—Grants to States for Aid to the Aged, Blind, [or] and Disabled [, or for Such Aid and Medical Assistance for the Aged] -----	
Title XVIII—Health Insurance for the Aged and Disabled -----	
Title XIX—Grants to States for Medical Assistance Programs -----	
Title XX—Federal Guaranteed Employment Opportunity Program for Heads of Families with Children -----	
Title XXI—Bureau of Child Care -----	

AN ACT

To provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED¹

	Page
[Sec. 1. Appropriation	610
[Sec. 2. State Old-Age and Medical Assistance Plans	610
[Sec. 3. Payment to States	613
[Sec. 4. Operation of State Plans	618
[Sec. 5. Administration	619
[Sec. 6. Definitions	619

[Appropriation

[Section 1. For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services, and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary"), State plans for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged.

[State Old-Age and Medical Assistance Plans

[Sec. 2. (a) A State plan for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged must—

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

[(2) provide for financial participation by the State;

[(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the

¹ Repealed effective January 1, 1974.

establishment or designation of a single State agency to supervise the administration of the plan;

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

[(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

[(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

[(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the State plan;

[(8) provide that all individuals wishing to make application for assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

[(9) provide, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

[(10) if the State plan includes old-age assistance—

[(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (i) the State agency may disregard not more than \$7.50 per month of any income and (ii) of the first \$80 per month of additional income which is earned the State agency may disregard not more than the first \$20 thereof plus one-half of the remainder;

[(B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

[(C) provide a description of the services (if any) which the State agency makes available to applicants for and recip-

ients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and

[(11) if the State plan includes medical assistance for the aged—

[(A) provide for inclusion of some institutional and some noninstitutional care and services;

[(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

[(C) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of such assistance to individuals who are residents of the State but are absent therefrom;

[(D) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

[(E) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan;

[(12) if the State plan includes assistance to or in behalf of individuals who are patients in institutions for mental diseases—

[(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

[(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution;

[(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions,

including appropriate medical treatment and other assistance; for services referred to in section 3(a) (4) (A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

[(D) provide methods of determining the reasonable cost of institutional care for such patients; and

[(13) if the State plan includes assistance to or in behalf of patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases.

[(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for assistance under the plan—

[(1) an age requirement of more than sixty-five years; or

[(2) any residence requirement which (A) in the case of applicants for old-age assistance excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

[(3) any citizenship requirement which excludes any citizen of the United States.

[(c) Nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

[(Payment to States

[(Sec. 3. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

[(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during each month of such quarter as old-age assistance under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

[(A) $\frac{31}{37}$ of such expenditures, not counting so much of any expenditure with respect to such month as exceeds the product of \$37 multiplied by the total number of recipients of old-age assistance for such month (which total number,

for purposes of this subsection, means (i) the number of individuals who received old-age assistance in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as old-age assistance in the form of medical or any other type of remedial care); plus

[(B) the larger of the following:

[(i) (I) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess with respect to such month as exceeds the product of \$38 multiplied by the total number of recipients of old-age assistance for such month, plus (II) 15 per centum of the total expended during such month as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such month as exceeds the product of \$15 multiplied by the total number of recipients of old-age assistance for such month, or

[(ii) (I) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditures with respect to such month as exceeds (a) the product of \$52 multiplied by the total number of such recipients of old-age assistance for such month, or (b) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of \$37 multiplied by such total number of such recipients, plus (II) the Federal percentage of the amount by which the total expended during such month as old-age assistance under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B) (ii), not counting so much of such excess with respect to such month as exceeds the product of \$38 multiplied by the total number of such recipients of old-age assistance for such month;

[(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

[(A) one-half of the total of the sums expended during such quarter as old-age assistance under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

[(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum

which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of \$45 multiplied by the total number of such recipients of old-age assistance for such month, or (II) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of \$37.50 multiplied by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of \$7.50 multiplied by the total number of such recipients of old-age assistance for such month;

[(3) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 6(c)) of the total amounts expended during such quarter as medical assistance for the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof); and

[(4) in the case of any State whose State plan approved under section 2 meets the requirements of subsection (c) (1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c) (1) and are provided (in accordance with the next sentence) to applicants for or recipients of assistance under the plan to help them attain or retain capability for self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c) (1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of assistance under the plan, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or

recipients of assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such assistance; plus

[(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act, are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

[(5) in the case of any State whose State plan approved under section 2 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.

[(b) The method of computing and paying such amounts shall be as follows:

[(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to

be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary may find necessary.

[(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

[(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

[(c) (1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 2 must provide that the State agency shall make available to applicants for recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision, the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.

[(d) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to patients in institutions for mental diseases shall be paid only to the extent that the State make a showing satisfactory to the Secretary that total expenditures in the State from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.

【Operation of State Plans

【Sec. 4. In the case of any State plan which has been approved under this title by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan finds—

[(1) that the plan has been so changed as to impose any age, residence, or citizenship requirement prohibited by section 2(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

[(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 2(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer imposed, and that there is no longer any such

failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[Administration

[Sec. 5. [Executed. Authorized appropriation for administrative expenses of the Social Security Board under this title for the fiscal year ending June 30, 1936.]

[Definitions

[Sec 6. (a) For the purposes of this title, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are sixty-five years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution). Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 2 includes provision for—

[(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

[(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

[(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

[(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

[(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

[(b) For purposes of this title, the term "medical assistance for the aged" means payment of part or all of the cost of the following care

and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals sixty-five years of age or older who are not recipients of old-age assistance (except, for any month, for recipients of old-age assistance who are admitted to or discharged from a medical institution during such month) but whose income and resources are insufficient to meet all of such cost—

- [(1) inpatient hospital services;
- [(2) skilled nursing-home services;
- [(3) physicians' services;
- [(4) outpatient hospital or clinic services;
- [(5) home health care services;
- [(6) private duty nursing services;
- [(7) physical therapy and related services;
- [(8) dental services;
- [(9) laboratory and X-ray services;
- [(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;
- [(11) diagnostic, screening, and preventive services; and
- [(12) any other medical care or remedial care recognized under State law;

except that such term does not include any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).

[(c) For purposes of this title, the term "Federal medical percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (i) the Federal medical percentage shall in no case be less than 50 per centum or more than 80 per centum, and (ii) the Federal medical percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8) (other than the proviso at the end thereof); except that the Secretary shall, as soon as possible after enactment of the Social Security Amendments of 1960, determine and promulgate the Federal medical percentage for each State—

[(1) for the period beginning October 1, 1960, and ending with the close of June 30, 1961, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for the fiscal year ending June 30, 1961 (which promulgation of the Federal medical percentage shall be conclusive for such period), and

[(2) for the period beginning, July 1, 1961, and ending with the close of June 30, 1963, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for such period (which promulgation of the Federal medical percentage shall be conclusive for such period).]

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**Federal Old-Age and Survivors Insurance Trust Fund and
Federal Disability Insurance Trust Fund**

Section 201. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Old-Age and Survivors Insurance Trust Fund". The Federal Old-Age and Survivors Insurance Trust Fund shall consist of the securities held by the Secretary of the Treasury for the Old-Age Reserve Account and the amount standing to the credit of the Old-Age Reserve Account on the books of the Treasury on January 1, 1940, which securities and amount the Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, and, in addition, *such gifts and bequests as may be made as provided in subsection (i) (1),¹ and such amounts as may be appropriated to, or deposited in, the Federal Old-Age and Survivors Insurance Trust Fund as hereinafter provided.* There is hereby appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1941, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes (including interest, penalties, and additions to the taxes) received under subchapter A of chapter 9 of the Internal Revenue Code of 1939 (and covered into the Treasury) which are deposited into the Treasury by collectors of internal revenue before January 1, 1951; and

(2) the taxes certified each month by the Commissioner of Internal Revenue as taxes received under subchapter A of chapter 9 of such Code which are deposited into the Treasury by collectors of internal revenue after December 31, 1950, and before January 1, 1953, with respect to assessments of such taxes made before January 1, 1951; and

(3) the taxes imposed by subchapter A of chapter 9 of such Code with respect to wages (as defined in section 1426 of such Code), and by chapter 21 (other than sections 3101(b) and 3111(b)) of the Internal Revenue Code of 1954 with respect to wages (as defined in section 3121 of such Code) reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 after December 31, 1950, or to the Secretary of the Treasury or his delegates pursuant to subtitle F of the Internal Revenue Code of 1954 after December 31, 1954, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such subchapter or chapter 21 (other than sections 3101(b) and 3111(b)) to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports, less the amounts specified in clause (1) of subsection (b) of this section; and

¹ Applies to gifts and bequests received after the date of enactment.

(4) the taxes imposed by subchapter E of chapter 1 of the Internal Revenue Code of 1939, with respect to self-employment income (as defined in section 481 of such Code), and by chapter 2 (other than section 1401(b)) of the Internal Revenue Code of 1954 with respect to self-employment income (as defined in section 1402 of such Code) reported to the Commissioner of Internal Revenue on tax returns under such subchapter or to the Secretary of the Treasury, or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such subchapter or chapter (other than section 1401(b)) to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns, less the amounts specified in clause (2) of subsection (b) of this section.

The amounts appropriated by clauses (3) and (4) shall be transferred from time to time from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such clauses (3) and (4) of this subsection.

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of *such gifts and bequests as may be made as provided in subsection (i) (1),¹ and of such amounts as may be appropriated to, or deposited in, such fund as provided in this section.* There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) (A) $\frac{1}{2}$ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, and (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of

¹ Applies to gifts and bequests received after the date of enactment.

the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) **[1.0]** 1.15 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1978, and so reported, (F) **[1.1]** 1.40 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 2011, and so reported, and (G) **[1.4]** 1.60 per centum of the wages (as so defined) paid after December 31, 2010, and so reported, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

(2) (A) $\frac{3}{8}$ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, and (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) **[0.75]** 0.83 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1978, (F) **[0.825]** 1.00 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 2011, and (G) **[0.915]** 0.935 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2010, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

(c) With respect to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (hereinafter in this title called the "Trust Funds") there is hereby created a body to be known as the Board of Trustees of the Trust Funds (hereinafter in this title called the "Board of Trustees") which Board of Trustees shall be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this title called the "Managing Trustee"). The Commissioner of Social Security shall serve as Secretary of the Board of Trustees. Such Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Funds;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;

(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;

(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of the old-age and survivors insurance and Federal-State unemployment compensation program; and

(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.

The report provided for in paragraph (2) above shall include a statement of the assets of, and the disbursements made from, the Trust Funds during the preceding fiscal year, an estimate of the expected future income to, and disbursements to be made from, the Trust Funds during each of the next ensuing five fiscal years, and a statement of the actuarial status of the Trust Funds. Such report shall also include an actuarial analysis of the benefit disbursements made from the Federal Old-Age and Survivors Insurance Trust Fund with respect to disabled beneficiaries. Such report shall be printed as a House document of the session of the Congress to which the report is made.

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

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

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, respectively.

(g) (1) (A) There are authorized to be made available for expenditure, out of any or all of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII), such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this title, *title XVI*; and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. During each fiscal year or after the close of such fiscal year (or at both times), the Secretary of Health, Education, and Welfare shall analyze the costs of administration of this title and title XVIII during the appropriate part or all of such fiscal year in order to determine the portion of such costs which should be borne by each of the Trust Funds *and (with respect to title XVI) by the general revenues of the United States* and shall certify to the Managing Trustee the amount, if any, which should be transferred among such Trust Funds in order to assure that (*after appropriations made pursuant to section 1601, and repayment to the Trust Funds from amounts so appropriated*) each of the Trust Funds *and the general revenues of the United States* bears its proper share of the costs incurred during such fiscal year for the part of the administration of this title and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. The Managing Trustee is authorized and directed to transfer any such amount (determined under the preceding sentence) among such Trust Funds in accordance with any certification so made.

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

(2) The Managing Trustee is directed to pay from time to time from the Trust Funds into the Treasury the amount estimated by him as taxes imposed under section 3101(a) which are subject to refund under section 6413(c) *and (e)* of the Internal Revenue Code of 1954 with respect to wages (as defined in section 1426 of the Internal Revenue Code of 1939 and section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1950. Such taxes shall be deter-

mined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 and to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections. Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in the ratio in which amounts were appropriated to such Trust Funds under clause (3) of subsection (a) of this section and clause (1) of subsection (b) of this section.

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

(h) Benefit payments required to be made under section 223, and benefit payments required to be made under subsection (b), (c), [or] (d), or (x) of section 202 to individuals entitled to benefits on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, shall be made only from the Federal Disability Insurance Trust Fund. All other benefit payments required to be made under this title (other than section 226) shall be made only from the Federal Old-Age and Survivors Insurance Trust Fund.

(i) (1) *The Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to any one or more of such Trust Funds or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of any of such Funds or any activity financed through such Funds.*

(2) *Any such gift accepted pursuant to the authority granted in paragraph (1) of this subsection shall be deposited in—*

- (A) *the specific trust fund designated by the donor or*
- (B) *if the donor has not so designated, the Federal Old-Age and Survivors Insurance Trust Fund.¹*

Old-Age and Survivors Insurance Benefit Payments

Old-Age Insurance Benefits

Sec. 202. (a) Every individual who—

- (1) is a fully insured individual (as defined in section 214(a)),
- (2) has attained age 62, and

¹ Applies to gifts and bequests received after the date of enactment.

(3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained the age of 65, shall be entitled to an old-age insurance benefit for each month, beginning with the first month after August 1950 in which such individual becomes so entitled to such insurance benefits and ending with the month preceding the month in which he dies. Except as provided in subsection (q) and subsection (w), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 215(a)) for such month.

Wife's Insurance Benefits

(b) (1) The wife (as defined in section 216(b)) and every divorced wife (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such wife or such divorced wife—

(A) has filed application for wife's insurance benefits,

(B) has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced wife, is not married, and

[(D)] (D) in the case of a divorced wife, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

[(i)] (i) if he had a period of disability which did not end before the month in which he became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time he becomes entitled to such benefits, or

[(ii)] (ii) if he did not have such a period of disability, at the time he became entitled to old-age insurance benefits, and—

[(E)] (E) is not entitled to old-age or disability insurance benefits or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual, shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with the first month in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs—

[(F)] (F) she dies,

[(G)] (G) such individual dies,

[(H)] (H) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 20 years immediately before the date the divorce became effective,

[(I)] (I) in the case of a divorced wife, she marries a person other than such individual,

[(J)] (J) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

[(K)] (J) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

[(L)] (K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.¹

(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

(3) In the case of any divorced wife who marries—

(A) an individual entitled to benefits under subsection (f) **[(or (h))]**, (h), or (x) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

Husband's Insurance Benefits

(c) (1) The husband (as defined in section 216(f)) of an individual entitled to old-age or disability insurance benefits, if such husband—

(A) has filed application for husband's insurance benefits,

(B) has attained age 62,

(C) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual—

(i) if she had a period of disability which did not end prior to the month in which she became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time she became entitled to such benefits, or

(ii) if she did not have such a period of disability, at the time she became entitled to such benefits, and filed proof of such support within two years after the month in which she filed application with respect to such period of disability or after the month in which she became entitled to such benefits, as the case may be, or, if she did not have such a period, two years after the month in which she became entitled to such benefits, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of his wife,

¹ Applies to the benefits payable under section 202 for month after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed after Sept. 30, 1972.

shall be entitled to a husband's insurance benefit for each month, beginning with the first month after August 1950 in which he becomes so entitled to such insurance benefits and ending with the month preceding the month in which any of the following occurs: he dies, his wife dies, they are divorced, or he becomes entitled to an old-age or disability insurance benefit, based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of his wife, or his wife is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) The provisions of subparagraph (C) of paragraph (1) shall (subject to subsection (s)) not be applicable in the case of any husband who—

(A) in the month prior to the month of his marriage to such individual was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (f) **[or (h)]**, (h), or (x);

(B) in the month prior to the month of his marriage to such individual had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d); or

(C) in the month prior to the month of his marriage to such individual he was entitled to, or on application therefor and attainment of the required age (if any) would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

(3) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife for such month.

Child's Insurance Benefits

(d) (1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time student and had not attained the age of 22, or (ii) is under a disability (as defined in section 223(d)) which began before he attained the age of **[eighteen]** 22, and ¹

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death,

or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed after Sept. 30, 1972.

death, at the beginning of such period of disability or at the time he became entitled to such benefits, shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding whichever of the following first occurs—

(D) the month in which such child dies, [marries, or is adopted (except for adoption by a stepparent, grandparent, aunt, uncle, brother, or sister subsequent to the death of such fully or currently insured individual),] or marries,¹

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time student during any part of such month.

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22, but only if he was not under a disability (as so defined) in such earlier month;² or

(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22,² the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22, but only if he was not under a disability (as so defined) in such earlier month.²

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. *No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.*²

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

¹ Applies to benefits for months beginning with month of enactment.

² See footnote on preceding page.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1) (C) unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h) (2) (B) or section 216(h) (3) shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1) (C) if, at such time, the child was living with or was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (e), (f), (g), **[or]** (h), *or* (x) of this section or under section 223(a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under section 223(a) or this subsection, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or this subsection unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entitled to benefits under section 223(a), he is entitled, for the month following such last month, to benefits under subsection (a) of this section.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1) (D) has occurred) beginning with the first month thereafter **[in which he is a full-time student and has not attained the age of 22 if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs: The first month during no part of which he is a full-time student, the month in which he attains the age of 22, or the first month in which an event specified in paragraph (1) (D) occurs.]** *in which he—*

(A) (i) *is a full-time student or is under a disability (as defined in section 223(d)). and (ii) had not attained the age of 22, or*

(B) *is under a disability (as so defined) which began before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability,*

but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1)(D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time student, or (ii) the month in which he attains the age of 22, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22.¹

(7) For the purposes of this subsection—

(A) A “full-time student” is an individual who is in full-time attendance as a student at an educational institution, as determined by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the institutions involved, except that no individual shall be considered a “full-time student” if he is paid by his employer while attending an educational institution at the request, or pursuant to a requirement, of his employer.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time student during any period of nonattendance at an educational institution at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an educational institution immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an educational institution immediately following such period.

(C) An “educational institution” is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a non-accredited school or college or university whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited.

(D) A child who attains age 22 at a time when he is a full-time student (as defined in subparagraph (A) of this paragraph and without the application of subparagraph (B) of such paragraph)

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed after Sept. 30, 1972.

*but has not (at such time) completed the requirements for, or received, a degree from a four-year college or university shall be deemed (for purposes of determining whether his entitlement to benefits under this subsection has terminated under paragraph (1)(F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1)(B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time (or, if the educational institution (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).*¹

(8) In the case of—

(A) an individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or²

(B) an individual entitled to disability insurance benefits, or
 [(B)] an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

a child of such individual adopted after such individual became entitled to such *old-age* or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1)

(C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D) (i) was legally adopted by such individual [before the end of the 24-month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, but only if—

[(i) proceedings for such adoption of the child had been instituted by such individual in or before the month in which began the period of disability of such individual which still exists at the time of such adoption (or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65), or

[(ii) such adopted child was living with such individual in such month; or

[(E) was legally adopted by such individual—

[(i) in an adoption which took place under the supervision of a public or private child-placement agency,

[(ii) in an adoption decreed by a court of competent jurisdiction within the United States,

¹ Applies to benefits for months after December 1972.

² Applies to benefits for months after December 1972 on the basis of applications filed in or after month of enactment, except that with respect to benefits for any month before month of enactment, application must be filed before seventh month of enactment.

[(iii) on a date immediately preceding which such individual had continuously resided for not less than one year within the United States:

[(iv) at a time prior to the attainment of age 18 by such child.] *in an adoption decreed by a court of competent jurisdiction within the United States,*

(i) *was living with such individual in the United States and receiving at least one-half of his support from such individual (I) if he is an individual referred to in subparagraph (A), for the year immediately before the month in which such individual became entitled to old-age insurance benefits or, if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, the month in which such period of disability began, or (II) if he is an individual referred to in subparagraph (B), for the year immediately before the month in which began the period of disability of such individual which still exists at the time of adoption (or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65), or the month in which such individual became entitled to disability insurance benefits, and*

(iii) *had not attained the age of 18 before he began living with such individual.*

In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of birth of such child.¹

[(9) If an individual entitled to old-age insurance benefits (but not an individual included under paragraph (8)) adopts a child after such individual becomes entitled to such benefits, such child shall be deemed not to meet the requirements of clause (i) of paragraph (1)(C) unless such child—

[(A) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

[(B) was legally adopted by such individual before the end of the 24-month period beginning with the month after the month in which such individual became entitled to old-age insurance benefits, but only if—

[(i) such child had been receiving at least one-half of his support from such individual for the year before such individual filed his application for old-age insurance benefits or, if such individual had a period of disability which continued

¹ Applies to benefits for months after December 1967 on the basis of an application filed in or after month of enactment, except that with respect to benefits for any month before January 1973, application must be filed before sixth month after month of enactment.

until he had become entitled to old-age insurance benefits, for the year before such period of disability began, and

[(ii) either proceedings for such adoption of the child had been instituted by such individual in or before the month in which the individual filed his application for old-age insurance benefits or such adopted child was living with such individual in such month.]

(9) (A) *A child who is a child of an individual under clause (3) of the first sentence of section 216(e) and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1) (C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.*

(B) *In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.¹*

Widow's Insurance Benefits

(e) (1) The widow (as defined in section 216(c)) and every surviving divorced wife (as defined in section 216(d)) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

(A) is not married,

(B) (i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (5),

(C) (i) has filed application for widow's insurance benefits, or was [entitled, after attainment of age 62, to wife's insurance benefits,] *entitled to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, or for the month preceding the month in which he died, [or] and (I) has attained age 65 or (II) is not entitled to benefits under subsection (a) or section 223, or¹*

(ii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained age [62] 65,² and

¹ Applies to benefits for months after December 1972 on the basis of applications filed on or after date of enactment.

² Applies to benefits for months after December 1972.

[(D) in the case of a surviving divorced wife who was not entitled to wife's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which he died, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

[(i) at the time of his death (or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of his death), or

[(ii) at the time he became entitled to old-age insurance benefits or disability insurance benefits (or, if such individual had a period of disability which did not end before the month in which he became entitled to such benefits, at the time such period began or at the time he became entitled to such benefits), and]¹

[(E)](D)¹ is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than [82½ percent of] the primary insurance amount of such deceased individual, shall be entitled to a widow's insurance benefit for each month, beginning with—

[(F)](E)¹ if she satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which she becomes so entitled to such insurance benefits, or

[(G)](F)¹ if she satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after her waiting period (as defined in paragraph (6)) in which she becomes so entitled to such insurance benefits, or

(ii) the first month during all of which she is under a disability and in which she becomes so entitled to such insurance benefits, but only if she was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (5) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, becomes entitled to an old-age insurance benefit equal to or exceeding [82½ percent of]¹ the primary insurance amount of such deceased individual, or, if she became entitled to such benefits before she attained age 60, the third month following the month in which her disability ceases (unless she attains age [62] 65¹ on or before the last day of such third month).

(2)(A) Except as provided in subsection (q) [and], paragraph (4) of this subsection, and subparagraph (B) of this paragraph, such widow's insurance benefit for each month shall be equal to [82½ percent of] the primary insurance amount of such deceased individual.

¹ Applies to benefits for months after December 1972 on the basis of applications filed on or after date of enactment.

(B) If the deceased individual (on the basis of whose wages and self-employment income a widow or surviving divorced wife is entitled to widow's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widow's insurance benefit of such widow or surviving divorced wife for any month shall, if the amount of the widow's insurance benefit of such widow or surviving divorced wife (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living, and

(ii) 82½ percent of the primary insurance amount of such deceased individual,

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) In the case of a widow or surviving divorced wife who marries—

(A) an individual entitled to benefits under subsection (f) [or (h)], (h), or (x) of this section, or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such widow's or surviving divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

(4) If a widow, after attaining the age of 60, marries an individual (other than one described in subparagraph (A) or (B) of paragraph (3)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (2) and subsection (q), such widow's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the husband dies or such marriage is otherwise terminated, shall be equal to one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based;

(5) The period referred to in paragraph (1)(B)(ii), in the case of any widow or surviving divorced wife, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income her benefits are or would be based, or

(B) the last month for which she was entitled to mother's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widow's insurance benefits on the basis of such wages and self-employment income terminated because her disability had ceased, and ending with the month before the month in which she attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(6) The waiting period referred to in paragraph (1) [(G)](F),¹ in the case of any widow or surviving divorced wife, is the earliest period of [six] *four*² consecutive calendar months—

(A) throughout which she has been under a disability, and

(B) which begins not earlier than with whichever of the following is the later: (i) the first day of the [eighteenth] *sixteenth*² month before the month in which her application is filed, or (ii) the first day of the [sixth] *fourth*² month before the month in which the period specified in paragraph (5) begins.

Widower's Insurance Benefits

(f) (1) The widower (as defined in section 216(g)) of an individual who died a fully insured individual, if such widower—

(A) has not remarried,

(B) (i) has attained age [62] 60³, or (ii) has attained age 50 but has not attained age [62] 60³ and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (6),

(C) has filed application for widower's insurance benefits or was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which she died, and (I) has attained age 65 or (II) is not entitled to benefits under subsection (a) or section 223,⁴

(D) (i) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual at the time of her death or, if such individual had a period of disability which did not end prior to the month in which she died, at the time such period began or at the time of her death, and filed proof of such support within two years after the date of such death, or, if she had such a period of

¹ Applies to benefits for months after December 1972 on the basis of applications filed on or after date of enactment.

² Applies with respect to applications for disability insurance benefits under section 223 of the Social Security Act, applications for widow's and widower's insurance benefits based on disability under section 202, and applications for disability determinations under section 216(f), filed—

(1) (month and year of enactment), or

(2) before (month and year of enactment) if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before (month and year of enactment), or

(B) the notice referred to in subparagraph (A) has been so given before (month and year of enactment) but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act (whether before, in, or after (month and year of enactment)) and the decision in such civil action has not become final before (month and year of enactment);

except that no monthly benefits under title II of the Social Security Act shall be payable or increased by reason of the amendments made by this section for any month before January 1973.

³ Applies to benefits for months after December 1972.

⁴ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

disability, within two years after the month in which she filed application with respect to such period of disability or two years after the date of such death, as the case may be, or (ii) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary from such individual at the time she became entitled to old-age or disability insurance benefits or, if such individual had a period of disability which did not end prior to the month in which she became so entitled, at the time such period began or at the time she became entitled to such benefits, and filed proof of such support within two years after the month in which she became entitled to such benefits, or, if she had such a period of disability, within two years after the month in which she filed application with respect to such period of disability or two years after the month in which she became entitled to such benefits, as the case may be,

(E) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than [82½ percent of]¹ the primary insurance amount of his deceased wife, shall be entitled to a widower's insurance benefit for each month, beginning with—

(F) if he satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which he becomes so entitled to such insurance benefits, or

(G) if he satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after his waiting period (as defined in paragraph (7)) in which he becomes so entitled to such insurance benefits, or

(ii) the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (6) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: he remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding [82½ percent of]¹ the primary insurance amount of his deceased wife, [or the third month] *or, if he became entitled to such benefits before he attained age 60, the third month*² following the month in which his disability ceases (unless he attains age [62] 60³ on or before the last day of such third month).

(2) The provisions of subparagraph (D) of paragraph (1) shall (subject to subsection (s)) not be applicable in the case of any individual who—

(A) in the month prior to the month of his marriage to such individual was entitled to, or on application therefor and attain-

¹ Applies to benefits for months after December 1972.

² Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

³ Applies to benefits for months after December 1972.

ment of age 62 in such prior month would have been entitled to, benefits under this subsection or subsection (h); or (x)

(B) in the month prior to the month of his marriage to such individual had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d); or

(C) in the month prior to the month of his marriage to such individual he was entitled to, or on application therefor and attainment of the required age (if any), would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

(3) (A) Except as provided in subsection (q), [and] paragraph (5), of this subsection, and subparagraph (B) of this paragraph, such widower's insurance benefit for each month shall be equal to [82½ percent of]¹ the primary insurance amount of his deceased wife.

(B) If the deceased wife (on the basis of whose wages and self-employment income a widower is entitled to widower's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widower's insurance benefit of such widower for any month shall, if the amount of the widower's insurance benefit of such widower (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

- (i) the amount of the old-age insurance benefit to which such deceased wife would have been entitled (after application of subsection (q)) for such month if such wife were still living; and
- (ii) 82½ percent of the primary insurance amount of such deceased wife;

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(4) In the case of a widower who remarries—

(A) an individual entitled to benefits under subsection (b), (e), (g), or (h), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such widower's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

(5) If a widower, after attaining the age of [62] 60,² marries an individual (other than one described in subparagraph (A) or (B) of paragraph (4)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (3) and subsection (q), such widower's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the wife dies or such marriage is otherwise terminated, shall be equal to one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based.

(6) The period referred to in paragraph (1) (B) (ii), in the case of any widower, is the period beginning with whichever of the following is the latest:

¹ Applies to benefits for months after December 1972.

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income his benefits are or would be based, or

(B) the month in which a previous entitlement to widower's insurance benefits on the basis of such wages and self-employment income terminated because his disability had ceased, and ending with the month before the month in which he attains age **[62]** 60,¹ or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(7) The waiting period referred to in paragraph (1)(G), in the case of any widower, is the earliest period of **[six]** *four* consecutive calendar months—

(A) throughout which he has been under a disability, and

(B) which begins not earlier than with whichever of the following is the later: (i) the first day of the **[eighteenth]** *sixteenth*³ month before the month in which his application is filed, or (ii) the first day of the **[sixth]** *fourth*³ month before the month in which the period specified in paragraph (6) begins.

Mother's Insurance Benefits

(g)(1) The widow and every surviving divorced mother (as defined in section 216(d)) of an individual who died a fully or currently insured individual, if such widow or surviving divorced mother—

(A) is not married,

(B) is not entitled to a widow's insurance benefit,

(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

(D) has filed application for mother's insurance benefits, or was entitled to wife's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which he died,

(E) at the time of filing such application has in her care a child of such individual entitled to a child's insurance benefit, and

(F) in the case of a surviving divorced mother—

[(i) at the time of such individual's death (or, if such individual had a period of disability which did not end before the month in which he died, at the time such period began or at the time of such death)—

[(I) she was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or

[(II) she was receiving substantial contributions from such individual (pursuant to a written agreement), or

[(III) there was a court order for substantial contributions to her support from such individual.**]**²

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

² Applies to benefits for months after December 1972 on the basis of applications filed on or after date of enactment.

[(ii)](z) the child referred to in subparagraph (E) is her son, daughter, or legally adopted child, and

[(iii)](zi) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income.

shall (subject to subsection (s)) be entitled to a mother's insurance benefit for each month, beginning with the first month after August 1950 in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, such widow or surviving divorced mother becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, she becomes entitled to a widow's insurance benefit, she remarries, or she dies. Entitlement to such benefits shall also end, in the case of a surviving divorced mother, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such surviving divorced mother is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

(2) Such mother's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

(3) In the case of a widow or surviving divorced mother who marries—

(A) an individual entitled to benefits under subsection (a), (f), [(or (h))] (h), or (x), or under section 223(a), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such widow or surviving divorced mother to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under section 223(a) or subsection (d) of this section, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or subsection (d) of this section unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entitled to benefits under section 223(a), he is entitled, for the month following such last month, to benefits under subsection (a) of this section.

Parent's Insurance Benefits

(h) (1) Every parent (as defined in this subsection) of an individual who died a fully insured individual if such parent—

(A) has attained age 62,

(B) (i) was receiving at least one-half of his support from such individual at the time of such individual's death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and (ii) filed proof of such support within

two years after the date of such death, or, if such individual had such a period of disability, within two years after the month in which such individual filed application with respect to such period of disability or two years after the date of such death, as the case may be,

(C) has not married since such individual's death,

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such amount is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), and

(E) has filed application for parent's insurance benefits.

shall be entitled to a parent's insurance benefit for each month beginning with the first month after August 1950 in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs: such parent dies, marries, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case).

(2)(A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of such deceased individual.

(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income, such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual.

(C) In any case in which—

(i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income, and

(ii) another parent of such deceased individual is entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent's benefits referred to in clause (i) was filed,

the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and the amount of the parent's insurance benefit of a parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of the deceased individual minus the amount (before the application of section 203(a)) of the benefit for such month of the parent referred to in clause (i).

(3) As used in this subsection, the term "parent" means the mother or father of an individual, a stepparent of an individual by a marriage

contracted before such individual attained the age of sixteen, or an adopting parent by whom an individual was adopted before he attained the age of sixteen.

(4) In the case of a parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (b), (e), (f), [or] (g), or (x), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such parent's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death.

Lump-Sum Death Payments

(i) Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount, or an amount equal to \$255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined by the Secretary to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

(1) if all or part of the burial expenses of such insured individual which are incurred by or through a funeral home or funeral homes remains unpaid, to such funeral home or funeral homes to the extent of such unpaid expenses, but only if (A) any person who assumed the responsibility for the payment of all or any part of such burial expenses files an application, prior to the expiration of two years after the date of death of such insured individual, requesting that such payment be made to such funeral home or funeral homes, or (B) at least 90 days have elapsed after the date of death of such insured individual and prior to the expiration of such 90 days no person has assumed responsibility for the payment of any such burial expenses;

(2) if all of the burial expenses of such insured individual which were incurred by or through a funeral home or funeral homes have been paid (including payments made under clause (1)), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such burial expenses; or

(3) if any part of the amount payable under this subsection remains after payments have been made pursuant to clauses (1) and (2), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid other expenses in connection with the burial of such insured individual, in the following order of priority: (A) expenses of opening and closing the grave of such insured individual, (B) expenses of providing the burial plot of such insured individual,

and (C) any remaining expenses in connection with the burial of such insured individual.

No payment (except a payment authorized pursuant to clause (1) (A) of the preceding sentence) shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(1) (1) are applicable, and who is returned to any State or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

Application for Monthly Insurance Benefits

(j) (1) An individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), **[or]** (h), *or* (x) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to the end of the twelfth month immediately succeeding such month. Any benefit under this title for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Secretary has certified for payment for such prior month.

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such appli-

cant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

Simultaneous Entitlement to Benefits

(k) (1) A child, entitled to child's insurance benefits on the basis of the wages and self-employment income of an insured individual, who would be entitled, on filing application, to child's insurance benefits on the basis of the wages and self-employment income of some other insured individual, shall be deemed entitled, subject to the provisions of paragraph (2) hereof, to child's insurance benefits on the basis of the wages and self-employment income of such other individual if an application for child's insurance benefits on the basis of the wages and self-employment income of such other individual has been filed by any other child who would, on filing application, be entitled to child's insurance benefits on the basis of the wages and self-employment income of both such insured individuals.

(2) (A) Any child who under the preceding provisions of this section is entitled for any month to **[more than one]** child's insurance **[benefit]** *benefits on the wages and self-employment income of more than one insured individual* shall, notwithstanding such provisions, be entitled to only one of such child's insurance benefits for such month **[, such benefit to be the one based on the wages and self-employment income of the insured individual who has the greatest primary insurance amount.]** *Such child's insurance benefits for such month shall be the benefit based on the wages and self-employment income of the insured individual who has the greatest primary insurance amount, except that such child's insurance benefits for such month shall be the largest benefit to which such child could be entitled under subsection (d) (without the application of section 203(a)) or subsection (m) if entitlement to such benefit would not, with respect to any person, result in a benefit lower (after the application of section 203(a)) than the benefit which would be applicable if such child were entitled on the wages and self-employment income of the individual with the greatest primary insurance amount. Where more than one child is entitled to child's insurance benefits pursuant to the preceding provisions of this paragraph, each such child who is entitled on the wages and self-employment income of the same insured individuals shall be entitled on the wages and self-employment income of the same such insured individual.*¹

¹ Applies only with respect to monthly benefits under title II for months after December 1972.

(B) Any individual (other than an individual to whom subsection (e) (4) or (f) (5) applies) who, under the [preceding] provisions of this section and under the provisions of section 223, is entitled for any month to more than one monthly insurance benefit (other than old-age or disability insurance benefit) under this title shall be entitled to only one such monthly benefit for such month, such benefit to be the largest of the monthly benefits to which he (but for this subparagraph (B)) would otherwise be entitled for such months. Any individual who is entitled for any month to more than one widow's or widower's insurance benefit to which subsection (e) (4) or (f) (5) applies shall be entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

(3) (A) If an individual is entitled to an old-age or disability insurance benefit for any month and to any other monthly insurance benefit for such month, such other insurance benefit for such month, after any reduction under subsection (q), *subsection (e) (2) or (f) (3)*,¹ and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such old-age or disability insurance benefit (after reduction under such subsection (q)).

(B) If an individual is entitled for any month to a widow's or widower's insurance benefit to which subsection (e) (4) or (f) (5) applies and to any other monthly insurance benefit under section 202 (other than an old-age insurance benefit), such other insurance benefit for such month, after any reduction under subparagraph (A), any reduction under subsection (q), and any reduction under section 203 (a), shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under such subparagraph (A) and such section 203(a).

(4) Any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this title shall be entitled to only the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.

Entitlement to Survivor Benefits Under Railroad Retirement Act

(1) If any person would be entitled, upon filing application therefor to an annuity under section 5 of the Railroad Retirement Act of 1937, or to a lump-sum payment under subsection (f) (1) of such section, with respect to the death of an employee (as defined in such Act) no lump-sum death payment, and no monthly benefit for the month in which such employee died or for any month thereafter, shall be paid under this section to any person on the basis of the wages and self-employment income of such employee.

Minimum Survivor's [or Dependent's] Benefit

(m) (1) In any case in which [the benefit of any] *an* individual [for any month under this section (other than subsection (a))] is, prior to reduction under subsection (k) (3) and subsection (q), less than the first figure in column IV of the table in section 215(a) and no other

¹ Applies to benefits for months after December 1972.

individual] is entitled to a monthly benefit under this section on the basis of the wages and self-employment income of a deceased individual for any month and no other person is (without the application of subsection [202] (j) (1)) entitled to a monthly benefit under this section for such month on the basis of [the same] such wages and self-employment income, such individual's benefit amount for such month [shall], prior to reduction under [such] subsection (k) (3) [and subsection (q)], be increased to the first figure in column IV of the table in section 215(a).], shall be not less than the first amount appearing in column IV of the table in (or deemed to be in) section 215(a), except as provided in paragraph (2).

(2) In the case of any such individual who is entitled to a monthly benefit under subsection (e) or (f), such individual's benefit amount, after reduction under subsection (q) (1), shall be not less than—

(A) \$84.50, if his first month of entitlement to such benefit is the month in which such individual attained age 62 or a subsequent month, or

(B) \$84.50 reduced under subsection (q) (1) as if retirement age as specified in subsection (q) (6) (A) (ii) were age 62 instead of the age specified in subsection (q) (9), if his first month of entitlement to such benefit is before the month in which he attained age 62.

(3) In the case of any individual whose benefit amount was computed (or recomputed) under the provisions of paragraph (2) and such individual was entitled to benefits under subsection (e) or (f) for a month prior to any month after 1972 for which a general benefit increase under this title (as defined in section 215(i) (3)) or a benefit increase under section 215(i) becomes effective, the benefit amount of such individual as computed under paragraph (2) without regard to the reduction specified in subparagraph (B) thereof shall be increased by the percentage increase applicable for such benefit increase, prior to the application of subsection (q) (1) pursuant to paragraph (2) (B) and subsection (q) (4).¹

Termination of Benefits Upon Deportation of Primary Beneficiary

(n) (1) If any individual is (after the date of enactment of this subsection) deported under paragraph (1), (2), (4), (5), (6), (7), (10), (11), (12), (14), (15), (16), (17), or (18) of section 241(a) of the Immigration and Nationality Act, then, notwithstanding any other provisions of this title—

(A) no monthly benefit under this section or section 223 shall be paid to such individual, on the basis of his wages and self-employment income, for any month occurring (i) after the month in which the Secretary is notified by the Attorney General that such individual has been so deported, and (ii) before the month in which such individual is thereafter lawfully admitted to the United States for permanent residence.

(B) if no benefit could be paid to such individual (or if no benefit could be paid to him if he were alive) for any month by reason of subparagraph (A), no monthly benefit under this section

¹ Applies to benefits for months after December 1972.

shall be paid, on the basis of his wages and self-employment income, for such month to any other person who is not a citizen of the United States and is outside the United States for any part of such month, and

(C) no lump-sum death payment shall be made on the basis of such individual's wages and self-employment income if he dies (i) in or after the month in which such notice is received, and (ii) before the month in which he is thereafter lawfully admitted to the United States for permanent residence.

Section 203 (b), (c), and (d) of this Act shall not apply with respect to any such individual for any month for which no monthly benefit may be paid to him by reason of this paragraph.

(2) As soon as practicable after the deportation of any individual under any of the paragraphs of section 241(a) of the Immigration and Nationality Act enumerated in paragraph (1) in this subsection, the Attorney General shall notify the Secretary of such deportation.

Application for Benefits by Survivors of Members and Former Members of the Uniformed Services

(o) In the case of any individual who would be entitled to benefits under subsection (d), (e), (g), **[or]** (h), *or* (x) upon filing proper application therefor, the filing with the Administrator of Veterans' Affairs by or on behalf of such individual of an application for such benefits, on the form described in section 3005 of Title 38, United States Code, shall satisfy the requirement of such subsection (d), (e), (g), **[or]** (h), *or* (x) that an application for such benefits be filed.

Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment

(p) In any case in which there is a failure—

(1) to file proof of support under subparagraph (C) of subsection (c) (1), clause (i) or (ii) of subparagraph (D) of subsection (f) (1), **[or]** subparagraph (B) of subsection (h) (1) *subparagraph (B) of subsection (h) (1), subparagraph (B) of subsection (x) (1)*, or under clause (B) of subsection (f) (1) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subparagraph or clause, or

(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection,

any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Secretary that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.

Reduction of Benefit Amounts for Certain Beneficiaries

(q) (1) If the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for **[each]** such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) $\frac{5}{9}$ of 1 percent of such amount if such benefit is an old-age **[, widow's or widower's]** insurance benefit, **[or]** $\frac{25}{36}$ of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit **[:]**, or $\frac{19}{40}$ of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by—

(B) (i) the number of months in the reduction period for such benefit (determined under paragraph (6) (A)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) if less, the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age **[or for any month thereafter.]**;

[A widow's or widower's insurance benefit reduced pursuant to the preceding sentence] and in the case of a widow or widower whose first month of entitlement to a widow's or widower's insurance benefit is a month before the month in which such widow or widower attains age 60, such benefit, reduced pursuant to the preceding provisions of this paragraph (and before the application of the second sentence of paragraph (8)), shall be further reduced by—

(C) **[43/198]** ~~$\frac{43}{240}$~~ of 1 percent of the amount of such benefit, multiplied by—

(D) (i) the number of months in the additional reduction period for such benefit (determined under paragraph (6) (B)), if such benefit is for a month before the month in which such individual attains **[retirement]** age 62, or

(ii) if less, the number of months in the additional adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains **[retirement]** age 62 or **[for]** any month thereafter.¹

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such months had such individual attained age 65 in the first month for which he most recently became entitled to a disability insurance benefit.

(3) (A) If the first month for which an individual both is entitled to a wife's, husband's, widow's, or widower's insurance benefit and has attained age 62 (in the case of a wife's or husband's insurance benefit) or age 50 (in the case of a widow's or widower's insurance

¹ Changes in this section apply to benefits for months after December 1972.

benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains age 65), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such wife's, husband's, widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance benefit and is not entitled to a disability insurance benefit, such individual's wife's, or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph (1) for such month, and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's or husband's insurance benefit (before reduction under this subsection) over such old-age insurance benefit (before reduction under this subsection).

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, widow's, or widower's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, widow's, or widower's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).

(E) If the first month for which an individual is entitled to an old-age insurance benefit (whether such first month occurs before, with, or after the month in which such individual attains the age of 65) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit to which such individual was first entitled for a month before she or he attained retirement age, then such old-age insurance benefit shall be reduced by whichever of the following is the larger:

(i) the amount by which (but for this subparagraph) such old-age insurance benefit would have been reduced under paragraph (1), or

(ii) the amount equal to the sum of the amount by which such widow's or widower's insurance benefit was reduced for the month in which such individual attained retirement age and the amount by which such old-age insurance benefit would be reduced under

paragraph (1) if it were equal to the excess of such old-age insurance benefit (before reduction under this subsection) over such widow's or widower's insurance benefit (before reduction under this subsection).

(F) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs with or after the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit to which such individual was first entitled for a month before she or he attained retirement age, then such disability insurance benefit for each month shall be reduced by whichever of the following is larger:

(i) the amount by which (but for this subparagraph) such disability insurance benefit would have been reduced under paragraph (2), or

(ii) the amount equal to the sum of the amount by which such widow's or widower's insurance benefit was reduced for the month in which such individual attained retirement age and the amount by which such disability insurance benefit would be reduced under paragraph (2) if it were equal to the excess of such disability insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection).

(G) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs before the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit, then such disability insurance benefit for each month shall be reduced by the amount such widow's insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained age 62 in the first month for which she or he most recently became entitled to a disability insurance benefit.

(4) If—

(A) an individual is or was entitled to a benefit subject to reduction under paragraph (1) or (3) of this subsection, and

(B) such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based,

then the amount of the reduction of such benefit for each month shall be computed separately (under paragraph (1) or (3), whichever applies) for the portion of such benefit which constitutes such benefit before any increase described in subparagraph (B), and separately (under paragraph (1) or (3), whichever applies to the benefit being increased) for each such increase. For purposes of determining the amount of the reduction under paragraph (1) or (3) in any such increase, the reduction period and the adjusted reduction period shall be determined as if such increase were a separate benefit to which such individual was entitled for and after the first month for which such increase is effective.

(5) (A) No wife's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by her with the Secretary, in accordance with regulations prescribed by him, in which she elects to receive wife's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which she has in her care (individually or jointly with the person on whose wages and self-employment income her wife's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A) (i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 203(c)(2))—

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the woman filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62, nor shall it be effective for any month to which subparagraph (A) (ii) applies.

(C) If a woman does not have in her care a child described in subparagraph (A) (ii) in the first month for which she is entitled to a wife's insurance benefit, and if such first month is a month before the month in which she attains age 65, she shall be deemed to have filed in such first month the certificate described in subparagraph (A) (i).

(D) No widow's insurance benefit for a month in which she has in her care a child of her deceased husband (or deceased former husband) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which she would have been entitled had she been entitled for such month to mother's insurance benefits on the basis of her deceased husband's (or deceased former husband's) wages and self-employment income.

(6) For the purposes of this subsection—

(A) the "reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the period—

(i) beginning—

(I) in the case of an old-age or husband's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit, or

(II) in the case of a wife's insurance benefit, with the first day of the first month for which a certificate described in paragraph (5) (A) (i) is effective, or

(III) in the case of a widow's or widower's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit or the first day of the month in which such individual attains age 60, whichever is the later, and

(ii) ending with the last day of the month before the month in which such individual attains retirement age; and

(B) the "additional reduction period" for an individual's widow's, or widower's insurance benefit is the period—

(i) beginning with the first day of the first month for which such individual is entitled to such benefit, but only if such individual has not attained age 60 in such first month, and

(ii) ending with the last day of the month before the month in which such individual attains age 60.

(7) For purposes of this subsection [,] the “adjusted reduction period” [or “additional adjusted reduction period”] for an individual’s old-age, wife’s, husband’s, widow’s, or widower’s insurance benefit is the reduction period [or additional reduction period (as the case may be)] prescribed in paragraph (6) (A) for such benefit, *and the “additional adjusted reduction period” for an individual’s, widow’s, or widower’s insurance benefit is the additional reduction period prescribed by paragraph (6) (B) for such benefit,*¹ excluding from each such period—

(A) any month in which such benefit was subject to deductions under section 203(b), 203(c) (1), 203(d) (1), or 222(b),

(B) in the case of wife’s insurance benefits, any month in which she had in her care (individually or jointly with the person on whose wages and self-employment income such benefit is based) a child of such person entitled to child’s insurance benefits,

(C) in the case of wife’s or husband’s insurance benefits, any month for which such individual was not entitled to such benefits because the spouse on whose wages and self-employment income such benefits were based ceased to be under a disability,

(D) in the case of widow’s insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5) (D),

(E) in the case of widow’s or widower’s insurance benefits, any month before the month in which she or he attained [retirement age] age 62, *and also for any later month before the month in which he attained retirement age,*¹ for which she or he was not entitled to such benefit because of occurrence of an event that terminated her or his entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

(8) This subsection shall be applied after reduction under section 203(a) and after application of section 215(g). If the amount of any reduction computed under paragraph (1), (2), or (3) is not a multiple of \$0.10, it shall be reduced to the next lower multiple of \$0.10.

(9) For purposes of this subsection, the term “retirement age” means age of 65 [with respect to an old-age, wife’s, or husband’s insurance benefit and age 62 with respect to a widow’s or widower’s insurance benefit].¹

Presumed Filing of Application by Individuals Eligible for Old-Age Insurance Benefits and for Wife’s or Husband’s Insurance Benefits

(r) (1) If the first month for which an individual is entitled to an old-age insurance benefit is a month before the month in which such individual attains age 65, and if such individual is eligible for a wife’s

¹ Applies to benefits for months after December 1972.

or husband's insurance benefit for such first month, such individual shall be deemed to have filed an application in such month for wife's or husband's insurance benefits.

(2) If the first month for which an individual is entitled to a wife's or husband's insurance benefit reduced under subsection (q) is a month before the month in which such individual attains age 65, and if such individual is eligible (but for section 202(k) (4)) for an old-age insurance benefit for such first month, such individual shall be deemed to have filed an application for old-age insurance benefits—

(A) in such month, or

(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit.

(3) For purposes of this subsection, an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, he would be entitled to such benefit for such month.

Child Aged 18 or Over Attending School

(s)(1) For the purposes of subsections (b) (1), (g) (1), (q) (5), and (q) (7) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 18 but is not in such month under a disability (as defined in section 223(d)) [which began before he attained such age,¹] shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month.

(2) Subsection (f) (4), and so much of subsections (b) (3), (d) (5), (e) (3), (g) (3), and (h) (4), of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 223(d)) [which began before such child attained the age of 18]¹ or had been under such a disability in the third month before the month in which such marriage occurred.

(3) Subsections (c) (2) (B) and (f) (2) (B) of this section, so much of subsections (b) (3), (d) (5), (e) (3), (g) (3), and (h) (4) of this section as follows the semicolon, the last sentence of subsection (c) of section 203, subsection (f) (1) (C) of section 203, and subsections (b) (3) (B), (c) (6) (B), (f) (3) (B), and (g) (6) (B) of section 216 shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 223(d)) [which began before such child attained the age of 18].¹

Suspension of Benefits of Aliens Who Are Outside the United States

(t)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual who is not a citizen or national of the United States for any month which is—

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed after Sept. 30, 1972.

(A) after the sixth consecutive calendar month during all of which the Secretary finds, on the basis of information furnished to him by the Attorney General or information which otherwise comes to his attention, that such individual is outside the United States, and

(B) prior to the first month thereafter for all of which such individual has been in the United States.

For purposes of the preceding sentence, after an individual has been outside the United States for any period of thirty consecutive days he shall be treated as remaining outside the United States until he has been in the United States for a period of thirty consecutive days.

(2) Paragraph (1) shall not apply to any individual who is a citizen of a foreign country which the Secretary finds has in effect a social insurance or pension system which is of general application in such country and under which—

(A) periodic benefits, or the actuarial equivalent thereof, are paid on account of old-age, retirement, or death, and

(B) individuals who are citizens of the United States but not citizens of such foreign country and who qualify for such benefits are permitted to receive such benefits or the actuarial equivalent thereof while outside such foreign country without regard to the duration of the absence.

(3) Paragraph (1) shall not apply in any case where its application would be contrary to any treaty obligation of the United States in effect on the date of the enactment of this subsection.

(4) Paragraph (1) shall not apply to any benefit for any month if—

(A) not less than forty of the quarters elapsing before such month are quarters of coverage for the individual on whose wages and self-employment income such benefit is based, or

(B) the individual on whose wages and self-employment income such benefit is based has, before such month, resided in the United States for a period or periods aggregating ten years or more, or

(C) the individual entitled to such benefit is outside the United States while in the active military or naval service of the United States, or

(D) the individual on whose wages and self-employment income such benefit is based died, before such month, either (i) while on active duty or inactive duty training (as those terms are defined in section 210(1)(2) and (3) as a member of a uniformed service (as defined in section 210(m)), or (ii) as the result of a disease or injury which the Administrator of Veterans' Affairs determines was incurred or aggravated in line of duty while on active duty (as defined in section 210(1)(2)), or an injury which he determines was incurred or aggravated in line of duty while on inactive duty training (as defined in section 210(1)(3)), as a member of a uniformed service (as defined in section 210(m)), if the Administrator determines that such individual was discharged or released from the period of such active duty or inactive duty training under conditions other than dishonorable, and if the Administrator certifies to the Secretary his determinations with respect to such individual under this clause, or

(E) the individual on whose employment such benefit is based had been in service covered by the Railroad Retirement Act which was treated as employment covered by this Act pursuant to the provisions of section 5(k)(1) of the Railroad Retirement Act; except that subparagraphs (A) and (B) of this paragraph shall not apply in the case of any individual who is a citizen of a foreign country that has in effect a social insurance or pension system which is of general application in such country and which satisfies subparagraph (A) but not subparagraph (B) of paragraph (2), or who is a citizen of a foreign country that has no social insurance or pension system of general application if at any time within five years prior to the month in which the Social Security Amendments of 1967 are enacted (or the first month thereafter for which his benefits are subject to suspension under paragraph (1)) payments to individuals residing in such country were withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123).

(5) No person who is, or upon application would be, entitled to a monthly benefit under this section for December 1956 shall be deprived, by reason of paragraph (1), of such benefit or any other benefit based on the wages and self-employment income of the individual on whose wages and self-employment income such monthly benefit for December 1956 is based.

(6) If an individual is outside the United States when he dies and no benefit may, by reason of paragraph (1) or (10) be paid to him for the month preceding the month in which he dies, no lump-sum death payment may be made on the basis of such individual's wages and self-employment income.

(7) Subsections (b), (c), and (d) of section 203 shall not apply with respect to any individual for any month for which no monthly benefit may be paid to him by reason of paragraph (1) of this subsection.

(8) The Attorney General shall certify to the Secretary such information regarding aliens who depart from the United States to any foreign country (other than a foreign country which is territorially contiguous to the continental United States) as may be necessary to enable the Secretary to carry out the purposes of this subsection and shall otherwise aid, assist, and cooperate with the Secretary in obtaining such other information as may be necessary to enable the Secretary to carry out the purposes of this subsection.

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

(10) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223, for any month beginning after June 30, 1968, to an individual who is not a citizen or national of the United States and who resides during such month in a foreign country if payments for such month to individuals residing in such country are withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123).

Effect of Conviction of Subversive Activities, etc.

(u) (1) If any individual is convicted of any offense (committed after the date of the enactment of this subsection) under—

(A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or

(B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended,

then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 223 is payable to such individual for the month in which he is convicted or for any month thereafter, in determining the amount of any such benefit payable to such individual for any such month, and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month, there shall not be taken into account—

(C) any wages paid to such individual or to any other individual in the calendar quarter in which such conviction occurs or in any prior calendar quarter, and

(D) any net earnings from self-employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1), been imposed with respect to any individual, the Attorney General shall notify the Secretary of such imposition.

(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted.

Waiver of Benefits

(v) (1) Notwithstanding any other provisions of this title, in the case of any individual who files a waiver pursuant to section 1402(h) of the Internal Revenue Code of 1954 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver; except that, if thereafter such individual's tax exemption under such section 1402(h) ceases to be effective, such waiver shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on his self-employment income for and after the first taxable year in which such tax exemption ceases to be effective and on his wages for and after the calendar year (if any) which begins in or with the beginning of such taxable year.

(2) *Notwithstanding any other provisions of this title, in the case of any individual who files a waiver pursuant to section 6413(e) of the*

Internal Revenue Code of 1954 and is granted an authorization for credit or refund thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver; except that, if thereafter such individual's authorization under such section 6413(e) ceases to be effective, such waiver shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on his wages beginning with the first day of the calendar year for which such authorization ceases to apply and on his self-employment income for and after his taxable year which begins in or with the beginning of such calendar year.

Increase in Old-Age Insurance Benefit Amounts on Account of Delayed Retirement¹

(w) (1) *If the first month for which an old-age insurance benefit becomes payable to an individual is not earlier than the month in which such individual attains age 65 (or his benefit payable at such age is not reduced under subsection (q)), the amount of the old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3)) which is payable without regard to this subsection to such individual shall be increased by—*

(A) $\frac{1}{12}$ of 1 percent of such amount, multiplied by

(B) the number (if any) of the increment months for such individual.

(2) *For purposes of this subsection, the number of increment months for any individual shall be a number equal to the total number of the months—*

(A) *which have elapsed after the month before the month in which such individual attained age 65 and prior to the month in which such individual attained age 72, and*

(B) *with respect to which—*

(i) *such individual was a fully insured individual (as defined in section 214(a)), and*

(ii) *such individual either was not entitled to an old-age insurance benefit or suffered deductions under section 203(b) or 203(c) in amounts equal to the amount of such benefit.*

(3) *For purposes of applying the provisions of paragraph (1), a determination shall be made under paragraph (2) for each year, beginning with 1972, of the total number of an individual's increment months through the year for which the determination is made and the total so determined shall be applicable to such individual's old-age insurance benefits beginning with benefits for January of the year following the year for which such determination is made; except that the total number applicable in the case of an individual who attains age 72 after 1972 shall be determined through the month before the month in which he attains such age and shall be applicable to his old-age insurance benefit beginning with the month in which he attains such age.*

¹ Applies to benefits for months after 1972.

(4) This subsection shall be applied after reduction under section 203(a).

Sister's and Brother's Insurance Benefits¹

(x) (1) Every sister or brother (as defined in this subsection) of an individual entitled to old-age or disability insurance benefits, or of an individual who died a fully insured individual, if such brother or sister—

(A) (i) is under a disability (as defined in section 223(d)) which began before he or she attained the age of 22, or (ii) in the case of a sister, has attained age 62,

(B) was receiving at least one-half of his or her support, as determined in accordance with regulations prescribed by the Secretary, from such deceased or insured individual—

(i) if such individual is living, at the time such individual became entitled to old-age or disability benefits,

(ii) if such individual has died, at the time of such death,

or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time of such death,

and has filed proof of such support within two years after the month in which such individual filed application with respect to such period of disability, became entitled to such benefits, or died, as the case may be, or (if later) within two years after the month in which the Social Security Amendments of 1972 is enacted,

(C) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits each of which is (i) less than one-half of the primary insurance amount of such individual if he is entitled to old-age or disability insurance benefits, or (ii) less than 32½ per centum of the primary insurance amount of such individual if he is deceased where the amount of the sister's or brother's insurance benefit is determinable under paragraph (2) (A) (or 75 per centum of such primary insurance amount if such individual is deceased in any other case),

(D) has filed application for sister's or brother's insurance benefits, and

(E) has not married after the date such individual became entitled to old-age or disability benefits or died,

shall be entitled to a sister's or brother's insurance benefit for each month, beginning with the first month he or she becomes so entitled to such insurance benefits and ending with the month preceding whichever of the following first occurs—

(F) the month in which such sister or brother dies,

(G) (i) if such individual is entitled to old-age or disability insurance benefits, the first month in which such sister or brother becomes entitled to an old-age insurance benefit or a disability insurance benefit which is equal to or exceeds one-half of the primary insurance amount of such individual, or (ii) if such individual

¹ Applies with respect to benefits under section 202(x) of the Act for months after December 1972 on the basis of applications for such benefits filed on or after the date of enactment of this Act.

has died, the first month in which such sister or brother becomes entitled to an old-age insurance benefit or a disability insurance benefit which is equal to or exceeds 82½ per centum of the primary insurance amount of such individual if the sister's or brother's insurance amount is determinable under paragraph (2)(A) (or 75 per centum of such primary insurance amount in any other case),

(H) the first month in which such individual is alive and is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits,

(I) in the case of a sister who has not attained the age of 62 or of a brother, the third month following the month in which such sister or brother ceases to be under a disability (as defined in section 223(d)) unless, in the case of such sister, she attains age 62 on or before the last day of such third month, or

(J) the month in which such sister or brother marries.

(2)(A) Except as provided in subparagraphs (B) and (C) of this paragraph, such sister's or brother's insurance benefit for each month shall be equal to—

(i) if the individual on the basis of whose wages and self-employment income the sister or brother is entitled to such benefit has not died prior to the end of such month, one-half of the primary insurance amount of such individual for such month, or

(ii) if such individual has died in or prior to such month, 82½ per centum of the primary insurance amount of such individual.

(B) For any month for which more than one person is entitled to sister's or brother's insurance benefits on the basis of the wages and self-employment income of an individual who died in or prior to such month, such benefit for each such person for each such month shall be equal to 75 per centum of the primary insurance amount of such insured individual.

(3) As used in this subsection—

(A) the term "sister" means a sister by the wholeblood, a sister by the halfblood, a stepsister by a marriage contracted before the sister attained age 18, or an adopted sister by an adoption that took place before the sister attained age 18; and

(B) the term "brother" means a brother by the wholeblood, a brother by the halfblood, a stepbrother by a marriage contracted before the brother attained age 18, or an adopted brother by an adoption that took place before the brother attained age 18.

(4) In the case of a sister or brother who marries—

(A) an individual entitled to benefits under this subsection or subsection (b), (e), (f), (g), or (h),

(B) an individual who attained the age of 18 and is entitled to benefits under subsection (d), or

(C) an individual entitled to benefits under subsection (a) but, with respect to a sister, only if she is under a disability (as defined in section 223(d)),

such sister's or brother's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage;

except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month during all of which such individual was under a disability (as defined in section 223(d)) unless he ceases to be so entitled by reason of his death.

Reduction of Insurance Benefits

Maximum Benefits

Sec. 203. (a) Whenever the total of monthly benefits to which individuals are entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an insured individual is greater than the amount appearing on column V of the table in (or deemed to be in) ¹ section 215(a) on the line on which appears in column IV such insured individual's primary insurance amount, such total of benefits shall be reduced to such amount; except that—

(1) when any of such individuals so entitled would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits on the basis of the wages and self-employment income of one or more other insured individuals, such total of benefits shall not be reduced to less than the smaller of: (A) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or (B) the last figure in column V of the table appearing in section 215(a), or

(2)² when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for August 1972 on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection were applicable in January

¹ Effective Jan. 1, 1974.

² P.L. 92-336, sec. 202(a)(2)(B), amended section 203(a) paragraph (2) in its entirety. Effective January 1, 1974, it will read as follows:

"(2) when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

(A) the amount determined under this subsection without regard to this paragraph,

(B) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

(C) if any persons are entitled to benefits on the basis of such wages and self-employment income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 215(l)(3)) or a benefit increase under the provisions of section 215(l), an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this title (excluding any part thereof determined under section 202(w)) for the month before such effective month (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase provided under such benefit increase (with any such increased amount which is not a multiple of \$0.10 being rounded to the next higher multiple of \$0.10);

but in any such case (1) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B) or (C), and (ii) if section 202(k)(2)(A) was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of subparagraph (B) or (C) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for the last month for which subparagraph (B) or (C) was applicable, or".

1971 or any prior month in determining the total of the benefits for persons entitled for any such month on the basis of such wages and self-employment income, such total of benefits for September 1972 or any subsequent month shall not be reduced to less than the larger of—

(A) the amount determined under this subsection without regard to this paragraph, or

(B) an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title for August 1972 (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each person for such month, by 120 percent and raising such increased amount, if it is not a multiple of \$0.10, to the next higher multiple of \$0.10; but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202(k) (2) (A) was applicable in the case of any such benefits for September 1972, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which section 202(k) (2) (A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for September 1972,

(3) when any of such individuals is entitled to monthly benefits as a divorced wife under section 202(b) or as a surviving divorced wife under section 202(e) for any month, the benefit to which she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced wife or surviving divorced wife were entitled to benefits for such month. In any case in which benefits are reduced pursuant to the preceding provisions of this subsection, such reduction shall be made after any deductions under this section and after any deductions under section 222(b). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased; except that if such total of benefits for such month includes any benefit or benefits under section 202(d) which are payable solely by reason of section 216(h) (3), the reduction shall be first applied to reduce (proportionately where there is more than one benefit so payable) the benefits so payable (but not below zero), **[or]**

(4) notwithstanding any other provision of law, when—

(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection and section 202(q) are applicable to such monthly benefits, and

(B) such individual's primary insurance amount is increased for the following month under any provision of this title,

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month to be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 202(q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202(q)) payable on the basis of such wages and self-employment income for such particular month [.] , or

(5) whenever the monthly benefits of such individuals are based on an insured individual's primary insurance amount which is determined under section 215(a)(3) and such primary insurance amount does not appear in column IV of the table in (or deemed to be in) section 215(a), the applicable maximum amount in column V of such table shall be the amount in such column that appears on the line on which the next higher primary insurance amount appears in column IV, or, if larger, the largest amount determined for such persons under this subsection for any month prior to October 1972.¹

Deductions on Account of Work

(b) Deductions, in amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

(1) such individual's benefit or benefits under section 202 for any month, and

(2) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits of all other persons for such month under section 202 based on such individual's wages and self-employment income,

if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (1) and (2). If the excess earnings so charged are less than such total benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's insurance bene-

¹ Applies to benefits for months after December 1972 and to lump-sum death payments for deaths after December 1972.

fits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

(A) an individual shall be deemed to be entitled to payments under section 202 equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the penultimate sentence thereof; and

(B) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222(b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month.

Deductions on Account of Noncovered Work Outside the United States or Failure To Have Child in Care

(c) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefits or benefit under section 202 for any month—

(1) in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States; or

(2) in which such individual, if a wife under age sixty-five entitled to a wife's insurance benefits, did not have in her care (individually or jointly with her husband) a child of her husband entitled to a child's insurance benefit and such wife's insurance benefit for such month was not reduced under the provisions of section 202(q); or

(3) in which such individual, if a widow entitled to a mother's insurance benefit, did not have in her care a child of her deceased husband entitled to a child's insurance benefit; or

(4) in which such individual, if a surviving divorced mother entitled to a mother's insurance benefit, did not have in her care a child of her deceased former husband who (A) is her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of her deceased former husband.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which paragraph (1) of section 202(s) applies or an

event specified in section 222(b) occurs with respect to such child. Subject to paragraph (3) of such section 202(s), no deductions shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month; nor shall any deduction be made under this subsection from any widow's insurance benefits for any month in which the widow or surviving divorced wife is entitled and has not attained age **[62]** 60¹ (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age **[62.]** 60¹ (but only if he became so entitled prior to attaining age 60).²

Deductions From Dependents' Benefits on Account of Noncovered Work Outside the United States by Old-Age Insurance Beneficiary

(d) (1) Deductions shall be made from any wife's, husband's, **[or]** child's, *sister's*, or *brother's* insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits, to which a wife, divorced wife, husband, **[or]** child, *sister*, or *brother* is entitled, until the total of such deduction equals such wife's, husband's, **[or]** child's, *sister's*, or *brother's* insurance benefit or benefits under section 202 for any month in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual who is entitled to old-age insurance benefits and on seven or more different calendar days of which such individual engaged in noncovered remunerative activity outside the United States.

Occurrence of More Than One Event

(e) If more than one of the events specified in subsections (c) and (d) and section 222(b) occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

Months to Which Earnings Are Charged

(f) For purposes of subsection (b)—

(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which

¹ Applies to benefits for months after December 1972.

² Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

he and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits under section 202(a) and other persons are entitled to benefits under section 202(b), (c), or (d) on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph, but subject to section 202(s), no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was age seventy-two or over, (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, (D) for which such individual is entitled to widow's insurance benefits and has not attained age [62] 60 (but only if she became so entitled prior to attaining age 60) or widower's insurance benefits and has not attained age [62] 60¹ (but only if he became so entitled prior to attaining age 60),² or (E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than [140] \$200 or the exempt amount as determined under paragraph (8).³

(2) As used in paragraph (1), the term "first month of such taxable year" means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), (D), and (E) thereof.

(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 50 per centum of his earnings for such year in excess of the product of [140] \$200 or the exempt amount as determined under paragraph (8), multiplied by the number of months in such year, except that [of the first \$1,200 of such excess (or all of such excess if it is less than \$1,200, an amount equal to one-half thereof shall not be included.], in determining an individual's excess earnings for the taxable year in which he attains age 72, there shall be excluded any earnings of such individual for the month in which he attains such age and any subsequent month (with any net earnings or net loss from self-employment in such year being prorated in an equi-

¹ Applies to benefits for months after December 1972.

² Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

³ Applies with respect to taxable years ending after December 1972.

table manner under regulations of the Secretary). The excess earnings as derived under the preceding sentence, if not a multiple of \$1, shall be reduced to the next lower multiple of \$1.²

(4) For purposes of clause (E) of paragraph (1)—

(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Secretary that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Secretary shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

(B) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (5) of this subsection) of more than ~~[\$140]~~ \$200 or the exempt amount as determined under paragraph (8) ¹ until it is shown to the satisfaction of the Secretary that such individual did not render such services in such month for more than such amount.

(5) (A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings for self-employment for such year, minus (ii) any net loss from self-employment for such year.

(B) For purposes of this section—

(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 211, except that paragraphs (1), (4), and (5) of section 211 (c) shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D), and

(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(9) of the Internal Revenue Code of 1954) taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i).

(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209; and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment.

¹ Applies with respect to taxable years ending after December 1972.

(D) In the case of an individual—

(i) who has attained the age of 65 on or before the last day of the taxable year, and

(ii) who shows to the satisfaction of the Secretary that he is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he attained the age of 65 and that the property to which the copyright or patent relates was created by his own personal efforts,

there shall be excluded from gross income any such royalties.

(E) For purposes of this section, there shall be excluded from the gross income of any individual for any taxable year the gain from the sale or other disposition, during such year, of any property of such individual which is not, by reason of the provisions of section 1221(3) (A) or (B) of the Internal Revenue Code of 1954, a capital asset of such individual as a taxpayer if—

(i) such individual attained age 65 on or before the last day of such taxable year; and

(ii) such individual shows to the satisfaction of the Secretary that such property was created by him, or (in the case such property consists of a letter, memorandum, or similar property) was prepared or produced for him prior to the taxable year in which such individual attained age 65.¹

(6) For purposes of this subsection, wages (determined as provided in paragraph (5) (C) which, according to reports received by the Secretary, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Secretary that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Secretary that his taxable year is not a calendar year.

(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 202(k) (3), and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled.

(8) (A) Whenever the Secretary pursuant to section 215(i) increases benefits effective with the first month of the calendar year following a cost-of-living computation quarter, he shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs (along with the publication of such benefit increase as required by sec-

¹ Effective in the case of taxable years beginning after December 31, 1972.

tion 215(i)(2)(D)) a new exempt amount which shall be effective (unless such new exempt amount is prevented from becoming effective by subparagraph (C) of this paragraph) with respect to any individual's taxable year which ends with the close of or after the calendar year with the first month of which such benefit increase is effective (or, in the case of an individual who dies during such calendar year, with respect to such individual's taxable year which ends, upon his death, during such year).

(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger—

(i) the exempt amount which was in effect with respect to months in the taxable year in which the determination under subparagraph (A) was made, or

(ii) the product of the exempt amount described in clause (i) and the ratio of (I) the average of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of the calendar year in which the determination under subparagraph (A) was made to (II) the average of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of 1973, or, if later, the first calendar quarter of the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination resulting in such an increase was made under section 230(a), with such product, if not a multiple of \$10, being rounded to the next higher multiple of \$10 where such product is a multiple of \$5 but not of \$10 and to the nearest multiple of \$10 in any other case.

Whenever the Secretary determines that the exempt amount is to be increased in any year under this paragraph, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance no later than August 15 of such year of the estimated amount of such increase, indicating the new exempt amount, the actuarial estimates of the effect of the increase, and the actuarial assumptions and methodology used in preparing such estimates.

(C) Notwithstanding the determination of a new exempt amount by the Secretary under subparagraph (A) (and notwithstanding any publication thereof under such subparagraph or any notification thereof under the last sentence of subparagraph (B)), such new exempt amount shall not take effect pursuant thereto if during the calendar year in which such determination is made a law increasing the exempt amount or providing a general benefit increase under this title (as defined in section 215(i)(3)) is enacted.

Penalty for Failure to Report Certain Events

(g) Any individual in receipt of benefits subject to deduction under subsection (c) (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Secretary prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer deductions in addition to those imposed under subsection (c) as follows:

(1) if such failure is the first one with respect to which an additional deduction is imposed by this subsection, such addi-

tional deduction shall be equal to his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than one month;

(2) if such failure is the second one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to two times his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than two months; and

(3) if such failure is the third or a subsequent one for which an additional deduction is imposed under this subsection, such additional deduction shall be equal to three times his benefit or benefits for the first month of the period for which there is a failure to report even though the failure to report is with respect to more than three months;

except that the number of additional deductions required by this subsection shall not exceed the number of months in the period for which there is a failure to report. As used in this subsection, the term "period for which there is a failure to report" with respect to any individual means the period for which such individual received and accepted insurance benefits under section 202 without making a timely report and for which deductions are required under subsection (c).

Report of Earnings to Secretary

(h)(1)(A) If an individual is entitled to any monthly insurance benefit under section 202 during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (5) of subsection (f), in excess of the product of ~~[\$140]~~ $\$166.66\frac{2}{3}$ or the exempt amount as determined under subsection (f)(8)¹ times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Secretary of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Secretary may by regulations prescribe. Such report need not be made for any taxable year (i) beginning with or after the month in which such individual attained the age of 72, or (ii) if benefit payments for all months (in such taxable year) in which such individual is under age 72 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection. The Secretary may grant a reasonable extension of time for making the report of earnings required in this paragraph if he finds that there is valid reason for a delay, but in no case may the period be extended more than three months.

(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year unless within such period the individual, or some other person entitled to benefits

¹ Applies with respect to taxable years ending after December 1972.

under this title on the basis of the same wages and self-employment income, files with the Secretary information showing that a benefit for such month is payable to such individual.

(2) If an individual fails to make a report required under paragraph (1), within the time prescribed by or in accordance with such paragraph, for any taxable year and any deduction is imposed under subsection (b) by reason of his earnings for such year, he shall suffer additional deductions as follows:

(A) if such failure is the first one with respect to which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202, except that if the deduction imposed under subsection (b) by reason of his earnings for such year is less than the amount of his benefit (or benefits) for the last month of such year for which he was entitled to a benefit under section 202, the additional deduction shall be equal to the amount of the deduction imposed under subsection (b) but not less than \$10;

(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

except that the number of the additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 202 and for which deductions are imposed under subsection (b) by reason of his earnings. In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

(3) If the Secretary determines, on the basis of information obtained by or submitted to him, that it may reasonably be expected that an individual entitled to benefits under section 202 for any taxable year will suffer deductions imposed under subsection (b) by reason of his earnings for such year, the Secretary may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Secretary may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Secretary has determined whether or not any deduction is imposed for such month under subsection (b). The Secretary is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make, at such

time or times as the Secretary may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Secretary such other information with respect to such earnings as the Secretary may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his earnings for such year. If, after the close of a taxable year of an individual entitled to benefits under section 202 for such year, the Secretary requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (5) of subsection (f) for such taxable year or any other information with respect to such earnings which the Secretary may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for such months thereof as the Secretary may specify) by reason of his earnings for such year.

Circumstances Under Which Deductions and Reductions Not Required

(i) In the case of any individual, deductions by reason of the provisions of subsection (b), (c), (g), or (h) of this section, or the provisions of section 222(b), shall, notwithstanding such provisions, be made from the benefit to which such individual is entitled only to the extent that such deductions reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household.

Attainment of Age Seventy-two

(j) For the purposes of this section, an individual shall be considered as seventy-two years of age during the entire month in which he attains such age.

Noncovered Remunerative Activity Outside the United States

(k) An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 210 and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 211(a). When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee), the term "United States" does not include the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa in the case of an alien who is not a resident of the United States (including the Common-

wealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) and the term "trade or business" shall have the same meaning as when used in Section 162 of the Internal Revenue Code of 1954.

Good Cause for Failure To Make Reports Required

(1) The failure of an individual to make any report required by subsection (g) or (h) (1) (A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Secretary that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.

Overpayments and Underpayments

Sec. 204. (a) Whenever the Secretary finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, under regulations prescribed by the Secretary, as follows:

(1) With respect to payment to a person of more than the correct amount, the Secretary shall decrease any payment under this title to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this title payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall apply any combination of the foregoing. A payment made under this title on the basis of an erroneous report of death by the Department of Defense of an individual in the line of duty while he is a member of the uniformed services (as defined in section 210 (m)) on active duty (as defined in section 210(1)) shall not be considered an incorrect payment for any month prior to the month such Department notifies the Secretary that such individual is alive.

(2) With respect to payment to a person less than the correct amount, the Secretary shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made in accordance with subsection (d).

(b) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience.

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

(d) If an individual dies before any payment due him under this title is completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who either (i) was living in the same household with the deceased at the time of his death or (ii) was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(2) if there is no person who meets the requirements of paragraph (1), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representative of the estate of the deceased individual **[, if any.]** *or, if none, to the person or persons, if any, who are determined by the Secretary, in accordance with regulations, to be related to the deceased individual by blood, marriage, or adoption and to be the appropriate person or persons to receive payment on behalf of the estate.*

Evidence, Procedure, and Certification for Payment

Sec. 205. (a) The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b) The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, widower, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered, he shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. Any such request with respect to such a decision must be filed within such period after such decision as may be prescribed in regulations of the Secretary, except that the period so prescribed may not be less than six months after notice of such decision is mailed to the individual making such request. The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

(c) (1) For the purposes of this subsection

(A) The term "year" means a calendar year when used with respect to wages and a taxable year (as defined in section 211(e)) when used with respect to self-employment income.

(B) The term "time limitation" means a period of three years, three months, and fifteen days.

(C) The term "survivor" means an individual's spouse, surviving divorced wife, surviving divorced mother, child, or parent, who survives such individual.

(2) (A) On the basis of information obtained by or submitted to the Secretary, and after such verification thereof as he deems necessary, the Secretary shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid

and such income was derived, as shown by such records at the time of such request.

(B) (i) *In carrying out his duties under subparagraph (A), the Secretary shall take affirmative measures to assure that social security account numbers will, to the maximum extent practicable, be assigned to all members of appropriate groups or categories of individuals by assigning such numbers (or ascertaining that such numbers have already been assigned):*

(I) *to or on behalf of children who are below school age at the request of their parents or guardians;*

(II) *to children of school age at the time of their first enrollment in school;*

(III) *to aliens at the time of their lawful admission to the United States either for permanent residence or under other authority of law permitting them to engage in employment in the United States and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment;*

(IV) *to any individual who is an applicant for or recipient of benefits under any program financed in whole or in part from Federal funds, including any child on whose behalf such benefits are claimed by another person; and*

(V) *to any other individual when it appears that he could have been but was not assigned an account number under the provisions of subclauses (I), (II), (III) or (IV) but only after such investigation as is necessary to establish to the satisfaction of the Secretary the identity of such individual, the fact that an account number has not already been assigned to such individual, and the fact that such individual is a citizen or a non-citizen who is not, because of his alien status, prohibited from engaging in employment.*

(ii) *The Secretary shall require of applicants for social security account numbers such evidence as may be necessary to establish the age, citizenship, or alien status, and true identity of such applicants, and to determine which (if any) social security account numbers have previously been assigned to such individual.*

(iii) *In carrying out the requirements of this subparagraph, the Secretary shall enter into such agreements as may be necessary with the Attorney General and other officials, and with State and local welfare agencies and school authorities (including nonpublic school authorities).*

(3) The Secretary's record shall be evidence for the purpose of proceedings before the Secretary or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of the periods in which such wages were paid and such income was derived. The absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Secretary may, if it is brought to his attention that any entry of wages or self-employment income in his records for such year is

erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in his records, as the case may be. After the expiration of the time limitation following any year—

(A) the Secretary's records (with changes, if any, made pursuant to paragraph (5)) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this title;

(B) the absence of an entry in the Secretary's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this title that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Secretary's records as to the self-employment income alleged to have been derived by an individual in such year shall be conclusive for the purposes of this title that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of his self-employment income for such year before the expiration of the time limitation following such year, in which case the Secretary shall include in his records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Secretary may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Secretary's records of the wages paid to, or the self-employment income derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Secretary's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this title when they should have been credited under the Railroad Retirement Act, or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act when they should have been credited under this title;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform his records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act, under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, under chapter 2 or 21 of the Internal Revenue Code of 1954, or under regulations made under authority of such title, subchapter, or chapter;

(ii) wage reports filed by a State pursuant to an agreement under section 218 or regulations of the Secretary, thereunder; or

(iii) assessments of amounts due under an agreement pursuant to section 218, if such assessments are made within the period specified in subsection (q) of such section, or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Secretary's records pursuant to this subparagraph;

(G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Secretary;

(H) to include wages paid during any period in such year to an individual by an employer if there is an absence of an entry in the Secretary's records of wages having been paid by such employer to such individual in such period;

(I) to enter items which constitute remuneration for employment under subsection (o), such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k) (3) of the Railroad Retirement Act of 1937; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Secretary as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F)) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individual only if he has previously been notified by the Secretary of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose

record is involved has previously been notified by the Secretary of the amount of such individual's wages and self-employment income for the period involved.

(7) Upon request in writing (within such period, after any change or refusal of a request for a change of his records pursuant to this subsection, as the Secretary may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual named therein, or by registered mail or by certified mail the Secretary shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in his records as may be required by such findings and decision.

(8) Decisions of the Secretary under this subsection shall be reviewable by commencing a civil action in the United States district court as provided in subsection (g).

(d) For the purpose of any hearing, investigation, or other proceeding authorized or directed under this title, or relative to any other matter within his jurisdiction hereunder, the Secretary shall have power to issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Secretary. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpoenas of the Secretary shall be served by anyone authorized by him (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpoena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpoenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) In case of contumacy by, or refusal to obey a subpoena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Secretary, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

(f) No person so subpoenaed or ordered shall be excused from attending and testifying or from producing books, records, correspondence, documents, or other evidence on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture; but no person shall be prosecuted or subjected to any penalty or forfeiture for, or on account of, any transaction, matter, or thing concerning which he is compelled, after having claimed his privilege against self-incrimination, to testify or produce evidence, except that such person so testifying shall not be exempt from prosecution and punishment for perjury committed in so testifying.

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the case for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or his decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(h) The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 24 of the Judicial Code of the United States to recover on any claim arising under this title.

(i) Upon final decision of the Secretary, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this title, the Secretary shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or

payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Treasury Department, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary: *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

(j) When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person.

(k) Any payment made after December 31, 1939, under conditions set forth in subsection (j), any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Secretary of incompetency prior to certification of payment, if otherwise valid under this title, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health, Education, and Welfare designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e).

(m) [Repealed.]

(n) The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 204(a) with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this title for such month.

Crediting of Compensation Under the Railroad Retirement Act

(o) If there is no person who would be entitled, upon application therefor, to an annuity under section 5 of the Railroad Retirement Act of 1937, or to a lump-sum payment under subsection (f)(1) of such section, with respect to the death of an employee (as defined in such Act), then, notwithstanding section 210(a)(9) of this Act, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 4 of such Act if wages are deemed to have been paid to such employee during such

month under subsection (a) or (e) of section 217 of this Act) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this title on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this title, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

Special Rules in Case of Federal Service

(p)(1) With respect to service included as employment under section 210 which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (1)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 210(o) are applicable *and including service, performed by a participant in guaranteed employment provided by the Work Administration, to which the provisions of section 210(p) are applicable*,¹ the Secretary shall not make determinations as to whether an individual has performed such service, the periods of such service, the amounts of remuneration for such service which constitute wages under the provisions of section 209, or the periods in which or for which such wages were paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954 and certifications made pursuant to this subsection. Such determinations shall be final and conclusive.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Secretary, to make certification to him with respect to any matter determinable for the Secretary by such head or his agents under this subsection, which the Secretary finds necessary in administering this title.

(3) The provisions of paragraphs (1) and (2) shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) the Secretary of Defense shall be deemed to

¹ Amendment in italic effective January 1, 1974.

be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of the Treasury shall be deemed to be the head of such instrumentality.

Expedited Benefit Payments

(q) (1) The Secretary shall establish and put into effect procedures under which expedited payment of monthly insurance benefits under this title will, subject to paragraph (4) of this subsection, be made as set forth in paragraphs (2) and (3) of this subsection.

(2) In any case in which—

(A) an individual makes an allegation that a monthly benefit under this title was due him in a particular month but was not paid to him, and

(B) such individual submits a written request for the payment of such benefit—

(i) in the case of an individual who received a regular monthly benefit in the month preceding the month with respect to which such allegation is made, not less than 30 days after the 15th day of the month with respect to which such allegation is made (and in the event that such request is submitted prior to the expiration of such 30-day period, it shall be deemed to have been submitted upon the expiration of such period), and

(ii) in any other case, not less than 90 days after the later of (I) the date on which such benefit is alleged to have been due, or (II) the date on which such individual furnished the last information requested by the Secretary (and such written request will be deemed to be filed on the day on which it was filed, or the ninetieth day after the first day on which the Secretary has evidence that such allegation is true, whichever is later),

the Secretary shall, if he finds that benefits are due, certify such benefits for payment, and payment shall be made within 15 days immediately following the date on which the written request is deemed to have been filed.

(3) In any case in which the Secretary determines that there is evidence, although additional evidence might be required for a final decision, that an allegation described in paragraph (2) (A) is true, he may make a preliminary certification of such benefit for payment even though the 30-day or 90-day periods described in paragraph (2) (B) (i) and (B) (ii) have not elapsed.

(4) Any payment made pursuant to a certification under paragraph (3) of this subsection shall not be considered an incorrect payment for purposes of determining the liability of the certifying or disbursing officer.

(5) For purposes of this subsection, benefits payable under section 228 shall be treated as monthly insurance benefits payable under this

title. However, this subsection shall not apply with respect to any benefit for which a check has been negotiated, or with respect to any benefit alleged to be due under either section 223, or section 202 to a wife, husband, or child of an individual entitled to or applying for benefits under section 223, or to a child who has attained age 18 and is under a disability, or to a widow or widower on the basis of being under a disability.

Representation of Claimants

Sec. 206. (a) The Secretary may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Secretary, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Secretary. The Secretary may, after due notice and opportunity for hearing, suspend or prohibit from further practice before him any such person, agent, or attorney who refuses to comply with the Secretary's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Secretary under this title, and any agreement in violation of such rules and regulations shall be void. Whenever the Secretary, in any claim before him for benefits under this title, makes a determination favorable to the claimant, he shall, if the claimant was represented by an attorney in connection with such claim fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim. If, as a result of such determination, such claimant is entitled to past-due benefits under this title, the Secretary shall, notwithstanding section 205(i), certify for payment (out of such past-due benefits) to such attorney an amount equal to whichever of the following is the smaller: (A) 25 per centum of the total amount of such past-due benefits, (B) the amount of the attorney's fee so fixed, or (C) the amount agreed upon between the claimant and such attorney as the fee for such attorney's services. Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter, or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Secretary shall be deemed guilty of a misdemeanor and, upon con-

viction thereof, shall for each offense be punished by a fine not exceeding \$500 or by imprisonment not exceeding one year, or both.

(b) (1) Whenever a court renders a judgment favorable to a claimant under this title who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Secretary may, notwithstanding the provisions of section 205(i), certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than \$500, or imprisonment for not more than one year, or both.

Assignment

Sec. 207. The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

Penalties

Sec. 208. Whoever—

(a) for the purpose of causing an increase in any payment authorized to be made under this title, or for the purpose of causing any payment to be made where no payment is authorized under this title, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939, or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954) as to—

(1) whether wages were paid or received for employment (as said terms are defined in this title and the Internal Revenue Code), or the amount of wages or the period during which paid or the person to whom paid; or

(2) whether net earnings from self-employment (as such term is defined in this title and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(3) whether a person entitled to benefits under this title had earnings in or for a particular period (as determined under section 203(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(b) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or

(c) at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title; or

(d) having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this title, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

(e) having made application to receive payment under this title for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000 or imprisoned for not more than one year, or both, or

(f) *willfully, knowingly, and with intent to deceive the Secretary as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Secretary with respect to any information required by the Secretary in connection with the establishment and maintenance of the records provided for in section 205(c)(2);¹ or*

(g) *for the purpose of causing an increase in any payment authorized under this title (or any other program financed in whole or in part from Federal funds), or for the purpose of causing a payment under this title (or any such other program) to be made when no payment is authorized thereunder, or for the purpose of obtaining (for himself or any other person) any payment or any other benefit to which he (or such other person) is not entitled—*

(1) *willfully, knowingly, and with intent to deceive, uses a social security account number, assigned by the Secretary (in the exercise of his authority under section 205(c)(2) to establish and maintain records) on the basis of false information furnished to the Secretary by him or by any other person; or*

(2) *with intent to deceive, falsely represents a number to be the social security account number assigned by the Secretary to him or to another person, when in fact such number is not the social security account number assigned by the Secretary to him or to such other person;¹ shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000 or imprisoned for not more than one year, or both.*

Definition of Wages

Sec. 209. For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including

¹ Applies with respect to information furnished to the Secretary after the date of enactment.

the cash value of all remuneration paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(a)(1) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$3,600 with respect to employment has been paid to an individual during any calendar year prior to 1955, is paid to such individual during such calendar year;

(2) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$4,200 with respect to employment has been paid to an individual during any calendar year after 1954 and prior to 1959, is paid to such individual during such calendar year;

(3) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$4,800 with respect to employment has been paid to an individual during any calendar year after 1958 and prior to 1966, is paid to such individual during such calendar year;

(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$6,600 with respect to employment has been paid to an individual during any calendar year after 1965 and prior to 1968, is paid to such individual during such calendar year;

(5) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$7,800 with respect to employment has been paid to an individual during any calendar year after 1967 and prior to 1972, is paid to such individual during such calendar year;

(6) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$9,000 with respect to employment has been paid to an individual during any calendar year after 1971 and prior to 1973 is paid to such individual during such calendar year;

(7) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$10,800 with respect to employment has been paid to an individual during any calendar year after 1972 and prior to 1974, is paid to such individual during such calendar year;

(8) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$12,000 with respect to employment has been paid to an individual during any calendar year after 1973 and prior to 1975, is paid to such individual during such calendar year;

(9) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1974 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;

(b) The amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his

dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of (1) retirement, or (2) sickness or accident disability, or (3) medical or hospitalization expenses in connection with sickness or accident disability, or (4) death;

(c) Any payment made to an employee (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement;

(d) Any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of six calendar months following the last calendar month in which the employee worked for such employer;

(e) Any payment made to, or on behalf of an employee or his beneficiary (1) from or to a trust exempt from tax under section 165(a) of the Internal Revenue Code of 1939 at the time of such payment or, in the case of a payment after 1954, under sections 401 and 501(a) of the Internal Revenue Code of 1954, unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or (2) under or to an annuity plan which, at the time of such payment, meets the requirements of section 165(a) (3), (4), (5), and (6) of the Internal Revenue Code of 1939, or, in the case of a payment after 1954 and prior to 1963, the requirements of section 401(a) (3), (4), (5), and (6) of the Internal Revenue Code of 1954, or (3) under or to an annuity plan which, at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1954, or (4) under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954;

(f) The payment by an employer (without deduction from the remuneration of the employee) (1) of the tax imposed upon an employee under section 1400 of the Internal Revenue Code of 1939, or in the case of a payment after 1954 under section 3101 of the Internal Revenue Code of 1954, or (2) of any payment required from an employee under a State unemployment compensation law;

(g) (1) Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(2) Cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than \$50. As used in this paragraph, the term "domestic service in a private home of the employer" does not include service described in section 210(f) (5);

(3) Cash remuneration paid by an employer in any calendar quarter to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than \$50. As used in this paragraph, the term "service not in the course of the employer's trade

or business" does not include domestic service in a private home of the employer and does not include service described in section 210(f)(5);

(h) (1) Remuneration paid in any medium other than cash for agricultural labor;

(2) Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (A) the cash remuneration paid in such year by the employer to the employee for such labor is \$150 or more, or (B) the employee performs agricultural labor for the employer on twenty days or more during such year for cash remuneration computed on a time basis;

(i) Any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62 [(if a woman) or age 65 (if a man)],¹ if he did not work for the employer in the period for which such payment is made. As used in this subsection, the term "sick pay" includes remuneration for service in the employ of a State, a political subdivision (as defined in section 218(b)(2)) of a State, or an instrumentality of two or more States, paid to an employee thereof for a period during which he was absent from work because of sickness;

(j) Remuneration paid by an employer in any quarter to an employee for service described in section 210(j)(3)(C) (relating to home workers), if the cash remuneration paid in such quarter by the employer to the employee for such service is less than \$50;

(k) Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1954;

(l) (1) Tips paid in any medium other than cash;

(2) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is \$20 or more; [or]

(m) Any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(1) upon or after the termination of an employee's employment relationship because of (A) death, (B) retirement for disability, or (C) retirement after attaining an age specified in the plan referred to in paragraph (2) or in a pension plan of the employer, and

(2) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated[.];

(n) *Any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;*¹ or

(o) *Any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) and such entitlement commenced*

*prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made.*¹

For purposes of this title, in the case of domestic service described in subsection (g) (2), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this title, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to \$1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (g) (2).

For purposes of this title, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 210(1) (1) are applicable, the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only his basic pay as described in section 102(10) of the Servicemen's and Veterans' Survivor Benefits Act.

For purposes of this title, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 210(o) are applicable, (1) the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only amounts certified as payable pursuant to section 5(c) or 6(1) of the Peace Corps Act, and (2) any such amount shall be deemed to have been paid to such individual at the time the service, with respect to which it is paid, is performed.

For purposes of this title, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954 or (if no statement including such tips is so furnished) at the time received.

For purposes of this title, in any case where an individual is a member of a religious order (as defined in section 3121(r) (2) of the Internal Revenue Code of 1954) performing service in the exercise of duties required by such order, and an election of coverage under section 3121(r) of such Code is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than \$100 a month.

¹ Applies in the case of any payment made after December 1972.

Definition of Employment

Sec. 210. For the purposes of this title—

Employment

(a) The term “employment” means any service performed after 1936 and prior to 1951 which was employment for the purposes of this title under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1950 either (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen of the United States as an employee (i) of an American employer (as defined in subsection (e)), or (ii) of a foreign subsidiary (as defined in section 3121(1) of the Internal Revenue Code of 1954) of a domestic corporation (as determined in accordance with section 7701 of the Internal Revenue Code of 1954) during any period for which there is in effect an agreement, entered into pursuant to section 3121(1) of the Internal Revenue Code of 1954, with respect to such subsidiary; except that, in the case of service performed after 1950, such term shall not include—

(1) Service performed by foreign agricultural workers (A) under contracts entered into in accordance with title V of the Agricultural Act of 1949, as amended, or (B) lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) Domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3) (A) Service performed by an individual in the employ of his spouse, and service performed by a child under the age of twenty-one in the employ of his father or mother;

(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) Service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft when outside the United States and (B) (i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) Service performed in the employ of any instrumentality of the United States, if such instrumentality is exempt from the tax imposed by section 3111 of the Internal Revenue Code of 1954 by virtue of any provisions of law which specifically refers to such section in granting such exemption;

(6) (A) Service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is covered by a retirement system established by a law of the United States;

(B) Service performed by an individual in the employ of an instrumentality of the United States if such an instrumentality was exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939 on December 31, 1950, and if such service is covered by a retirement system established by such instrumentality; except that the provisions of this subparagraph shall not be applicable to—

(i) service performed in the employ of a corporation which is wholly owned by the United States;

(ii) service performed in the employ of a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Home Loan Bank, or a Federal Credit Union;

(iii) service performed in the employ of a State, county, or community committee under the Production and Marketing Administration;

(iv) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; or

(v) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instru-

- mentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;
- (C) Service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such
- ing Administration;
 - (i) as the President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress;
 - (ii) in the legislative branch;
 - (iii) in a penal institution of the United States by an inmate thereof;
 - (iv) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training;
 - (v) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or
 - (vi) by any individual to whom subchapter III of chapter 83 of title 5, United States Code, does not apply because such individual is subject to another retirement system (other than the retirement system of the Tennessee Valley Authority);
- (7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—
- (A) service included under an agreement under section 218,
 - (B) service which, under subsection (k), constitutes covered transportation service,
 - (C) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title —
 - (i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and
 - (ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate,
- [or]**

(D) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis[;], or

(E) *service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (C) shall apply;*¹

(8) (A) Service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, *except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under section 3121(r) of the Internal Revenue Code of 1954 is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;*

(B) Service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) of the Internal Revenue Code of 1954, which is exempt from income tax under section 501(a) of such Code, but this subparagraph shall not apply to service performed during the period for which a certificate, filed pursuant to section 3121(k) of the Internal Revenue Code of 1954, is in effect if such service is performed by an employee—

(i) whose signature appears on the list filed by such organization under such section 3121(k),

(ii) who became an employee of such organization after the calendar quarter in which the certificate (other than a certificate referred to in clause (iii)) was filed, or

¹ Applies to services performed on and after the first day of the first calendar quarter beginning on or after the date of enactment.

(iii) who, after the calendar quarter in which the certificate was filed with respect to a group described in paragraph (1) (E) of such section 3121(k), became a member of such group,

except that this subparagraph shall apply with respect to service performed by an employee as a member of a group described in such paragraph (1) (E) with respect to which no certificate is in effect;

(9) Service performed by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954;

(10) (A) Service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501 of the Internal Revenue Code of 1954, if the remuneration for such service is less than \$50;

[(B) Service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university;]

(B) *Service performed in the employ of—*

(i) *a school, college, or university, or*

(ii) *an organization described in section 509(a)(3) of the Internal Revenue Code of 1954 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 with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services in its employ performed by a student referred to in section 218(c)(5) are covered under the agreement between the Secretary of Health, Education, and Welfare and such State entered into pursuant to section 218;*

*if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;*¹

(11) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) Service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

¹ Applies to services performed after Dec. 31, 1972.

(13) Service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14) (A) Service performed by an individual under the age of eighteen in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) Service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) Service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act (59 Stat. 669);

(16) Service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) Service in the employ of any organization which is performed (A) in any quarter during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a non-immigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)); or

(19) Service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be.

Included and Excluded Service

(b) If the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (9) of subsection (a).

American Vessel

(c) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

American Aircraft

(d) The term "American aircraft" means an aircraft registered under the laws of the United States.

American Employer

(e) The term "American employer" means an employer which is (1) the United States or any instrumentality thereof, (2) a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing, (3) an individual who is a resident of the United States, (4) a partnership, if two-thirds or more of the partners are residents of the United States, (5) a trust, if all of the trustees are residents of the United States, or (6) a corporation organized under the laws of the United States or of any State.

Agricultural Labor

(f) The term "agricultural labor" includes all service performed—
(1) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife.
(2) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush

and other debris left by a hurricane, if the major part of such service is performed on a farm.

(3) In connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15(g) of the Agricultural Marketing Act, as amended, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes.

(4)(A) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed.

(B) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For the purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than twenty at any time during the calendar quarter in which such service is performed.

(5) On a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

The provisions of subparagraphs (A) and (B) of paragraph (4) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption.

Farm

(g) The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

State

(h) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(i) The term "United States" when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Employee

(j) The term "employee" means—
(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2) of this subsection) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or drycleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

Covered Transportation Service

(k)(1) Except as provided in paragraph (2), all services performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system is, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment in connection with the operation of such part of the transportation system acquired by the State or political subdivision.

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) For the purposes of this subsection—

(A) The term “general retirement system” means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this title, and some of such employees become employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term “political subdivision” includes an instrumentality of (i) a State, (ii) one or more political subdivisions of a State, or (iii) a State and one or more of its political subdivisions.

Service in the Uniformed Services

(1)(1) Except as provided in paragraph (4), the term “employment” shall, notwithstanding the provisions of subsection (a) of this section, include service performed after December 1956 by an individual as a member of a uniformed service on active duty; but such term

shall not include any such service which is performed while on leave without pay.

(2) The term "active duty" means "active duty" as described in section 102 of the Servicemen's and Veterans' Survivor Benefits Act, except that it shall also include "active duty for training" as described in such section.

(3) The term "inactive duty training" means "inactive duty training" as described in such section 102.

(4) (A) Paragraph (1) of this subsection shall not apply in the case of any service, performed by an individual as a member of a uniformed service, which is creditable under section 4 of the Railroad Retirement Act of 1937. The Railroad Retirement Board shall notify the Secretary of Health, Education, and Welfare, as provided in section 4(p) (2) of that Act, with respect to all such service which is so creditable.

(B) In any case where benefits under this title are already payable on the basis of such individual's wages and self-employment income at the time such notification (with respect to such individual) is received by the Secretary, the Secretary shall certify no further benefits for payment under this title on the basis of such individual's wages and self-employment income, or shall recompute the amount of any further benefits payable on the basis of such wages and self-employment income, as may be required as a consequence of subparagraph (A) of this paragraph. No payment of a benefit to any person on the basis of such individual's wages and self-employment income, certified by the Secretary prior to the end of the month in which he receives such notification from the Railroad Retirement Board, shall be deemed by reason of this subparagraph to have been an erroneous payment or a payment to which such person was not entitled. The Secretary shall, as soon as possible after the receipt of such notification from the Railroad Retirement Board, advise such Board whether or not any such benefit will be reduced or terminated by reason of subparagraph (A), and if any such benefit will be so reduced or terminated, specify the first month with respect to which such reduction or termination will be effective.

Member of a Uniformed Service

(m) The term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component of a uniformed service as defined in section 102(3) of the Servicemen's and Veterans' Survivor Benefits Act) or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

- (1) a retired member of any of those services;
- (2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;
- (3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the

United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from or at, a place for final acceptance or for entry upon active duty in the military or naval service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Universal Military Training and Service Act, has been selected for active military or naval service; and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

Crew Leader

(n) The term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

Peace Corps Volunteer Service

(o) The term "employment" shall, notwithstanding the provisions of subsection (a), include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act.

Service Performed Under Contract by Participants in Guaranteed Employment

(p) *The term "employment" shall notwithstanding the provisions of subsection (a), include service performed by a participant in guaranteed employment provided by the Work Administration under title XX, but only if—*

(1) such service is performed for or on behalf of an employer pursuant to a contract entered into between the Work Administration and such employer under section 2052(e); and

(2) the remuneration paid by the Work Administration to such participant to compensate him for the performance of such service would have constituted wages (within the meaning of section 209) if—

(A) such participant had performed such service as an employee of such employer; and

(B) such employer had paid such remuneration to such participant to compensate him for the performance of such service.

Self-Employment

Sec. 211. For the purposes of this title—

Net Earnings From Self-Employment

(a) The term “net earnings from self-employment” means the gross income, as computed under Subtitle A of the Internal Revenue Code of 1954, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of income or loss described in section 702(a)(9) of the Internal Revenue Code of 1954, from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary income or loss—

(1) There shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares), together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant with respect to any such agricultural or horticultural commodity;

(2) There shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof); unless such dividends and interest (other than interest described in section 35 of the Internal Revenue Code of 1954) are received in the course of a trade or business as a dealer in stocks or securities;

(3) There shall be excluded any gain or loss (A) which is considered under Subtitle A of the Internal Revenue Code of 1954 as gain or loss from the sale or exchange of a capital asset, (B) from the cutting of timber or the disposal of timber, coal, or iron ore, if section 631 of the Internal Revenue Code of 1954 applies to such gain or loss, or (C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither (i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor (ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) The deduction for net operating losses provided in section 172 of such Code shall not be allowed;

(5) (A) If any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife;

(B) If any portion of a partner's distributive share of the ordinary net income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1954;

(7) An individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), [and] section 119 (relating to meals and lodging furnished for the convenience of the employer) [of the Internal Revenue Code of 1954 and, in addition, if he is a citizen of the United States performing such service as an employee of an American employer (as defined in section 210(e)) or as a minister in a foreign country who has a congregation which is composed predominantly of citizens of the United States, without regard to], and section 911 (relating to earned income from sources without the United States) and section 931 (relating to income from sources within possessions of the United States) of [such Code] *the Internal Revenue Code of 1954*;¹

(8) The term "possession of the United States" as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) of the Internal Revenue Code of 1954 shall be deemed not to include the Virgin Islands, Guam, or American Samoa; [and]

(9) There shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary of the Treasury or his delegate, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class

¹ Applies with respect to taxable years beginning after Dec. 31, 1972.

or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A) [1]; and

(10) *In the case of an individual who has been a resident of the United States during the entire taxable year, the exclusion from gross income provided by section 911(a)(2) of the Internal Revenue Code of 1954 shall not apply.*¹

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based upon the ordinary net income or loss of the partnership for any taxable year of the partnership (even though beginning prior to 1951) ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 210(f)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than \$2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66 $\frac{2}{3}$ percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than \$2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than \$1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be \$1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1954 applies) is not more than \$2,400, his distributive share of income described in section 702(a)(9) of such Code derived from such trade or business may, at his option, be deemed to be an amount equal to 66 $\frac{2}{3}$ percent of his distribu-

¹ Applies with respect to taxable years beginning after Dec. 31, 1972.

tive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1954 applies) is more than \$2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(9) of such Code derived from such trade or business (computed under this subsection without regard to this sentence) is less than \$1,600, his distributive share of income described in such section 702(a)(9) derived from such trade or business may, at his option, be deemed to be \$1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (g), or by a partnership of which an individual is a member on a regular basis as defined in subsection (g), but only if such individual's net earnings from self-employment in the taxable year as determined without regard to this sentence are less than \$1,600 and less than 66⅔ percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed \$1,600.¹

¹ Applies with respect to taxable years beginning after Dec. 31, 1972.

Self-Employment Income

(b) The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a non-resident alien individual) during any taxable year beginning after 1950; except that such term shall not include—

(1) That part of the net earnings from self-employment which is in excess of—

(A) For any taxable year ending prior to 1955, (i) \$3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) For any taxable year ending after 1954 and prior to 1959, (i) \$4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) For any taxable year ending after 1958 and prior to 1966, (i) \$4,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(D) For any taxable year ending after 1965 and prior to 1968, (i) \$6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(E) For any taxable year ending after 1967 and beginning prior to 1972, (i) \$7,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(F) For any taxable year beginning after 1971 and prior to 1973, (i) \$9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(G) For any taxable year beginning after 1972 and prior to 1974, (i) \$10,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(H) For any taxable year beginning after 1973 and prior to 1975, (i) \$12,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(I) For any taxable year beginning in any calendar year after 1974, (i) an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or

(2) The net earnings from self-employment, if such net earnings for the taxable year are less than \$400.

An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purposes of this subsection, be considered to be a nonresident alien individual.

Trade or Business

(c) The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954, except that such terms shall not include—

(1) The performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in

which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Secretary pursuant to section 218;

(2) The performance of service by an individual as an employee other than—

(A) service described in section 210(a)(14)(B) performed by an individual who has attained the age of eighteen,

(B) service described in section 210(a)(16),

(C) service described in section 210(a)(11), (12), or (15) performed in the United States by a citizen of the United States,

(D) service described in paragraph (4) of this subsection, and

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Secretary pursuant to section 218;

(3) The performance of service by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954;

(4) The performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) The performance of service by an individual during the period for which an exemption under section 1402(h) of the Internal Revenue Code of 1954 is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under section 1402(e) of the Internal Revenue Code of 1954 is effective with respect to him.

Partnership and Partner

(d) The term “partnership” and the term “partner” shall have the same meaning as when used in subchapter K of chapter 1 of the Internal Revenue Code of 1954.

Taxable Year

(e) The term “taxable year” shall have the same meaning as when used in subtitle A of the Internal Revenue Code of 1954; and the taxable year of any individual shall be a calendar year unless he has a different taxable year for the purposes of subtitle A of such Code, in which case his taxable year for the purposes of this title shall be the same as his taxable year under such subtitle A.

Partner's Taxable Year Ending as Result of Death

(f) In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interests.

Regular Basis

(g) An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than \$400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.¹

Crediting of Self-Employment Income to Calendar Quarters

Sec. 212. For the purposes of determining average monthly wage and quarters of coverage the amount of self-employment income derived during any taxable year shall be credited to calendar quarters as follows:

(a) In the case of a taxable year which is a calendar year the self-employment income of such taxable year shall be credited equally to each quarter of such calendar year.

(b) In the case of any other taxable year the self-employment income shall be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

Quarter and Quarter of Coverage

Definitions

Sec. 213. (a) For the purposes of this title—

(1) The term "quarter", and the term "calendar quarter", means a period of three calendar months ending on March 31, June 30, September 30, or December 31.

¹ Applies with respect to taxable years beginning after Dec. 31, 1972.

(2) The term "quarter of coverage" means a quarter in which the individual has been paid \$50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with \$100 or more of self-employment income, except that—

(i) no quarter after the quarter in which such individual died shall be a quarter of coverage, and no quarter any part of which was included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

(ii) if the wages paid to any individual in any calendar year equal to \$3,000 in the case of a calendar year before 1951, or \$3,600 in the case of a calendar year after 1950 and before 1955, or \$4,200 in the case of a calendar year after 1954 and before 1959, or \$4,800 in the case of a calendar year after 1958 and before 1966, or \$6,600 in the case of a calendar year after 1965 and before 1968, or \$7,800 in the case of a calendar year after 1967 and before 1972, or \$9,000 in the case of a calendar year after 1971 and before 1973, or \$10,800 in the case of a calendar year after 1972 and before 1974, or \$12,000 in the case of a calendar year after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective, each quarter of such year shall (subject to clause (i)) be a quarter of coverage;

(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals \$3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or \$4,200 in the case of a taxable year ending after 1954 and before 1959, or \$4,800 in the case of a taxable year ending after 1958 and before 1966, or \$6,600 in the case of a taxable year after 1965 and before 1968, or \$7,800 in the case of a taxable year ending after 1967, or \$9,000 in the case of a taxable year beginning after 1971 and before 1973, or \$10,800 in the case of a taxable year beginning after 1972 and before 1974, or \$12,000 in the case of a taxable year beginning after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 230) which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974, each quarter any part of which falls in such year shall (subject to clause (i)) be a quarter of coverage;

(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954, then, subject to clause (i), (a) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed \$100 but are less than \$200; (b) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed \$200 but are less than \$300;

(c) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed \$300 but are less than \$400; and (d) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are \$400 or more; and

(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter.

If in the case of any individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954, the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 214(a)(3) are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.

Crediting of Wages Paid in 1937

(b) With respect to wages paid to an individual in the six-month periods commencing either January 1, 1937, or July 1, 1937; (A) if wages of not less than \$100 were paid in any such period, one-half of the total amount thereof shall be deemed to have been paid in each of the calendar quarters in such period; and (B) if wages of less than \$100 were paid in any such period, the total amount thereof shall be deemed to have been paid in the latter quarter of such period, except that if in any such period, the individual attained age sixty-five, all of the wages paid in such period shall be deemed to have been paid before such age was attained.

Alternative Method for Determining Quarters of Coverage With Respect to Wages in the Period From 1937 to 1950

(c) For purposes of section 214(a), an individual shall be deemed to have one quarter of coverage for each \$400 of his total wages prior to 1951 (as defined in section 215(d)(1)(C)), except where—

- (1) such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to him for periods after 1950, or
- (2) such individual's elapsed years (for purposes of section 214(a)(1)) are less than 7.

Insured Status for Purposes of Old-Age and Survivors Insurance Benefits

Sec. 214. For the purposes of this title

Fully Insured Individual

(a) The term "fully insured individual" means any individual who had not less than—

(1) one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or, if later, the year in which he attained age 21) and before

[(A) in the case of a woman, the year in which she died or (if earlier) the year in which she attained age 62,

[(B) in the case of a man who has died, the year in which he died or (if earlier) the year in which he attained age 65, or

[(C) in the case of a man who has not died, the year in which he attained (or would attain) age 65, except] *the year in which he died or (if earlier) the year in which he attained age 62, except*¹

that in no case shall an individual be a fully insured individual unless he has at least 6 quarters of coverage; or

(2) 40 quarters of coverage; or

(3) in the case of an individual who died before 1951, 6 quarters of coverage;

not counting as an elapsed year for purposes of paragraph (1) any year any part of which was included in a period of disability (as defined in section 216(i)).

Currently Insured Individual

(b) The term "currently insured individual" means any individual who had not less than six quarters of coverage during the thirteen-quarter period ending with (1) the quarter in which he died, (2) the quarter in which he became entitled to old-age insurance benefits, (3) the quarter in which he became entitled to primary insurance benefits under this title as in effect prior to the enactment of this section, or (4) in the case of any individual entitled to disability insurance benefits, the quarter in which he most recently became entitled to disability insurance benefits, not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage.

¹ Applies in the case of a man who attains (or would attain) age 62 after December 1974. In the case of a man who attains or will attain age 62 in 1973, the figure "65" shall be deemed to read "64". In the case of a man who attains or will attain age 62 in 1974, the figure "65" shall be deemed to read "63".

Computation of Primary Insurance Amount

Sec. 215. For the purposes of this title—

(a) The primary insurance amount of an insured individual shall be determined as follows:

(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided in *paragraphs* (2) and (3) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

(A) the amount in column IV of the following table (or, if larger, the amount in column IV of the latest table deemed to be such table under subsection (i) (2) (D))¹ on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

(B) the amount in column IV of such table on the line on which in column II appears his primary insurance amount (as determined under subsection (c)); or

(C) the amount in column IV of such table on the line on which in column I appears his primary insurance benefit (as determined under subsection (d)).

(2) In the case of an individual who was entitled to a disability insurance benefit for the month before the month in which he died, became entitled to old-age insurance benefits, or attained age 65, [such primary insurance amount shall be the amount in column IV of such table which is equal to the primary insurance amount upon which such disability insurance benefit is based; except that if such individual was entitled to a disability insurance benefit under section 223 for the month before the effective month of a new table (whether enacted by another law or deemed to be such table under subsection (i) (2) (D))² and in the following month became entitled to an old-age insurance benefit, or he died in such following month then his primary insurance amount for such following month shall be the amount in column IV of the new table on the line on which in column II of such table appears his primary insurance amount for the month before the effective month of the table (as determined under subsection (c)) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based. For purposes of this paragraph, the term "primary insurance amount" with respect to any individual means only a primary insurance amount determined under paragraph (1) (and such individual's benefits shall be deemed to be based upon the primary insurance amount as so determined).] *such primary insurance amount shall be—*

(A) *the amount in column IV of such table which is equal to the primary insurance amount upon which such disability insurance benefit is based; except that if such individual was entitled to a disability insurance benefit under section 223 for the month before the effective month of a new table (whether*

¹ Effective Jan. 1, 1975.

² Applies with respect to taxable years beginning after Dec. 31, 1972.

enacted by another law or deemed to be such table under subsection (i) (2) (D)) and in the following month became entitled to an old-age insurance benefit, or he died in such following month, then his primary insurance amount for such following month shall be the amount in column IV of the new table on the line on which in column II of such table appears his primary insurance amount for the month before the effective month of the table (as determined under subsection (c)) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based. For purposes of this paragraph, the term "primary insurance amount" with respect to any individual means only a primary insurance amount determined under paragraph (1) (and such individual's benefits shall be deemed to be based upon the primary insurance amount as so determined); or

(B) an amount equal to the primary insurance amount upon which such disability insurance benefit is based if such primary insurance amount was determined under paragraph (3).

(3) Such primary insurance amount shall be an amount equal to \$10 multiplied by the individual's years of coverage in excess of 10 in any case in which such amount is higher than the individual's primary insurance amount as determined under paragraph (1) or (2).

For purposes of paragraph (3), an individual's "years of coverage" is the number (not exceeding 30) equal to the sum of (i) the number (not exceeding 14 and disregarding any fraction) determined by dividing the total of the wages credited to him (including wages deemed to be paid prior to 1951 to such individual under section 217, compensation under the Railroad Retirement Act of 1937 prior to 1951 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 231) for years after 1936 and before 1951 by \$900, plus (ii) the number equal to the number of years after 1950 each of which is a computation base year (within the meaning of subsection (b) (2) (C)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 217, compensation under the Railroad Retirement Act of 1937 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 229) and self-employment income of not less than 25 percent of the maximum amount which, pursuant to subsection (e), may be counted for such year.¹

¹ Applies to benefits for months after December 1972 and to lump-sum death payments for deaths after December 1972.

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1971 Act)		III (Average monthly wage)		IV (Primary insurance amount)		V (Maximum family benefits)	
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—		Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—		And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—	
At least—	But not more than—	At least—	But not more than—	At least—	But not more than—	At least—	But not more than—	At least—	But not more than—
\$16.21	\$16.20	\$70.40		\$77		\$76	\$84.50	\$126.80	
16.85	16.84	71.50		78		78	85.80	128.80	
17.61	17.60	73.10		79		80	87.80	131.70	
18.41	18.40	74.50		81		81	89.40	134.20	
19.25	19.24	75.80		82		83	91.00	136.50	
20.01	20.00	77.40		84		85	92.90	139.40	
20.65	20.64	78.80		86		87	94.60	141.90	
21.29	21.28	80.10		88		89	96.20	144.30	
21.89	21.88	81.70		90		90	98.10	147.20	
22.29	22.28	83.10		91		92	99.80	149.70	
22.69	22.68	84.50		93		94	101.40	152.20	
23.09	23.08	85.80		95		96	103.00	154.50	
23.45	23.44	87.40		97		97	104.90	157.40	
23.77	23.76	88.90		98		99	106.70	160.10	
24.21	24.20	90.60		100		101	108.80	163.20	
24.61	24.60	91.90		102		102	110.30	165.50	
25.01	25.00	93.40		103		104	112.10	168.20	
25.49	25.48	95.10		105		106	114.20	171.30	
25.93	25.92	96.60		107		107	116.00	173.90	
26.41	26.40	98.20		108		109	117.90	176.90	
26.95	26.94	99.70		110		113	119.70	179.60	
27.47	27.46	101.10		114		118	121.40	182.10	
28.01	28.00	102.70		119		122	123.30	185.00	
28.69	28.68	104.20		123		127	125.10	187.70	
29.26	29.25	105.90		128		132	127.10	190.70	
29.69	29.68	107.30		133		136	128.80	193.20	
30.37	30.36	108.70		137		141	130.50	195.80	
30.93	30.92	110.40		142		146	132.50	198.80	
31.37	31.36	111.90		147		150	134.30	201.50	
31.77	31.76	113.30		151		155	136.00	204.00	
32.01	32.00	115.00		156		160	138.00	207.00	
32.61	32.60	116.40		161		164	139.70	209.60	
33.21	33.20	118.00		165		169	141.60	212.40	
33.89	33.88	119.50		170		174	143.40	215.20	
34.51	34.50	121.00		175		178	145.20	217.80	
35.01	35.00	122.60		179		183	147.20	220.80	
35.81	35.80	124.00		184		188	148.80	223.20	
36.41	36.40	125.70		189		193	150.90	226.40	
37.09	37.08	127.20		194		197	152.70	229.10	
37.61	37.60	128.60		198		202	154.40	231.60	
38.21	38.20	130.30		203		207	156.40	234.60	
39.13	39.12	131.80		208		211	158.20	237.30	
39.69	39.68	133.10		212		216	159.80	239.70	
40.34	40.33	134.80		217		221	161.80	242.70	
41.13	41.12	136.30		222		225	163.60	245.40	
41.77	41.76	137.90		226		230	165.50	248.30	
42.45	42.44	139.40		231		235	167.30	251.00	
43.21	43.20	141.10		236		239	169.40	254.10	
43.77	43.76	142.50		240		244	171.00	257.80	
44.45	44.44	143.90		245		249	172.70	263.10	
44.89	44.88	145.60		250		253	174.80	267.30	
	45.60	147.10		254		258	176.60	272.60	
		148.40		259		263	178.10	277.80	
		150.10		264		267	180.20	282.00	
		151.60		268		272	182.00	287.30	
		153.20		273		277	183.90	292.60	
		154.70		278		281	185.70	296.80	
		156.20		282		286	187.50	302.10	
		157.90		287		291	189.50	307.40	
		159.20		292		295	191.10	311.60	
		160.90		296		300	193.10	316.80	

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1971 Act)		III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—		Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—	At least—	But not more than—	At least—	But not more than—		
		162.40		301	305	194.90	322.10
		163.80		306	309	196.60	326.40
		165.50		310	314	198.60	331.70
		166.90		315	319	200.30	337.00
		168.30		320	323	202.00	341.20
		170.00		324	328	204.00	346.50
		171.50		329	333	205.80	351.80
		173.20		334	337	207.90	356.00
		174.50		338	342	209.40	361.20
		176.00		343	347	211.20	366.50
		177.70		348	351	213.30	370.70
		179.10		352	356	215.00	376.00
		180.80		357	361	217.00	381.30
		182.20		362	365	218.70	385.50
		183.60		366	370	220.40	390.80
		185.30		371	375	222.40	396.00
		186.80		376	379	224.20	400.40
		188.50		380	384	226.20	405.60
		189.80		385	389	227.80	410.90
		191.30		390	393	229.60	415.10
		193.00		394	398	231.60	420.40
		194.40		399	403	233.30	425.70
		196.10		404	407	235.40	429.90
		197.40		408	412	236.90	435.20
		198.80		413	417	238.60	440.40
		200.20		418	421	240.30	444.60
		201.80		422	426	242.20	449.90
		203.10		427	431	243.80	455.20
		204.50		432	436	245.40	460.50
		206.10		437	440	247.40	462.60
		207.40		441	445	248.90	465.30
		208.80		446	450	250.60	467.90
		210.40		451	454	252.50	470.00
		211.70		455	459	254.10	472.60
		213.10		460	464	255.80	475.20
		214.50		465	468	257.40	477.40
		216.10		469	473	259.40	480.00
		217.40		474	478	260.90	482.70
		218.80		479	482	262.60	484.80
		220.40		483	487	264.50	487.50
		221.70		488	492	266.10	490.10
		223.10		493	496	267.80	492.20
		224.70		497	501	269.70	494.80
		226.00		502	506	271.20	497.40
		227.40		507	510	272.90	499.60
		228.80		511	515	274.60	502.20
		230.30		516	520	276.40	504.90
		231.70		521	524	278.10	506.90
		233.10		525	529	279.80	509.60
		234.70		530	534	281.70	512.20
		236.00		535	538	283.20	514.40
		237.40		539	543	284.90	517.00
		239.00		544	548	286.80	519.60
		240.30		549	553	288.40	522.30
		241.70		554	556	290.10	523.80
		242.90		557	560	291.50	526.00
		244.20		561	563	293.10	527.60
		245.50		564	567	294.60	529.70
		246.80		568	570	296.20	531.30
		248.00		571	574	297.60	533.30
		249.30		575	577	299.20	535.00
		250.50		578	581	300.60	537.00

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1971 Act)		III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—		Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—			At least—	But not more than—		
		251.80		582	584	302.20	538.60
		253.00		585	588	303.60	540.80
		254.40	[251.40]	589	591	305.30	542.30
		255.60		592	595	306.80	544.50
		256.90		596	598	308.30	546.00
		258.10		599	602	309.80	548.20
		259.40		603	605	311.30	549.80
		260.60		606	609	312.80	551.80
		262.00		610	612	314.40	553.50
		263.20		613	616	315.90	555.50
		264.50		617	620	317.40	557.70
		265.70		621	623	318.90	559.20
		267.00		624	627	320.40	561.40
		268.20		628	630	321.90	563.30
		269.50		631	634	323.40	566.10
		270.80		635	637	325.00	568.70
		272.10		638	641	326.60	571.50
		273.30		642	644	328.00	574.00
		274.60		645	648	329.60	576.80
		275.80		649	652	331.00	579.30
		276.60		653	656	332.00	581.00
		277.40		657	660	332.90	582.60
		278.40		661	665	334.10	584.70
		279.40		666	670	335.30	586.80
		280.40		671	675	336.50	588.90
		281.40		676	680	337.70	591.00
		282.40		681	685	338.90	593.10
		283.40		686	690	340.10	595.20
		284.40		691	695	341.30	597.30
		285.40		[699] 696	700	342.50	599.40
		286.40		701	705	343.70	601.50
		287.40		706	710	344.90	603.60
		288.40		711	715	346.10	605.70
		289.40		716	720	347.30	607.80
		290.40		721	725	348.50	609.90
		291.40		726	730	349.70	612.00
		292.40		731	735	350.90	614.10
		293.40		736	740	352.10	616.20
		294.40		741	745	353.30	618.30
		295.40		746	750	354.50	620.40
				751	755	355.50	622.20
				756	760	356.50	623.90
				761	765	357.50	625.70
				766	770	358.50	627.40
				771	775	359.50	629.20
				776	780	360.50	630.90
				781	785	361.50	632.70
				786	790	362.50	634.40
				791	795	363.50	636.20
				796	800	364.50	637.90
				801	805	365.50	639.70
				806	810	366.50	641.40
				811	815	367.50	643.20
				816	820	368.50	644.90
				821	825	369.50	646.70
				826	830	370.50	648.40
				831	835	371.50	650.20
				836	840	372.50	651.90
				841	845	373.50	653.70
				846	850	374.50	655.40
				851	855	375.50	657.20
				856	860	376.50	658.90

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1971 Act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
			861	865	377.50	660.70
			866	870	378.50	662.40
			871	875	379.50	664.20
			876	880	380.50	665.90
			881	885	381.50	667.70
			886	890	382.50	669.40
			891	895	383.50	671.20
			896	900	384.50	672.90
			901	905	385.50	674.70
			906	910	386.50	676.40
			911	915	387.50	678.20
			916	920	388.50	679.90
			921	925	389.50	681.70
			926	930	390.50	683.40
			931	935	391.50	685.20
			936	940	392.50	686.90
			941	945	393.50	688.70
			946	950	394.50	690.40
			951	955	395.50	692.20
			956	960	396.50	693.90
			961	965	397.50	695.70
			966	970	398.50	697.40
			971	975	399.50	699.20
			976	980	400.50	700.90
			981	985	401.50	702.70
			986	990	402.50	704.40
			991	995	403.50	706.20
			996	1,000	404.50	707.90

Average Monthly Wage

(b) (1) For the purposes of column III of the table appearing in subsection (a) of this section, an individual's "average monthly wage" shall be the quotient obtained by dividing—

(A) the total of his wages paid in and self-employment income credited to his "benefit computation years" (determined under paragraph (2)), by

(B) the number of months in such years.

(2) (A) The number of an individual's "benefit computation years" shall be equal to the number of elapsed years (determined under paragraph (3) of this subsection), reduced by five, except that the number of an individual's benefit computation years shall in no case be less than two.

(B) An individual's "benefit computation years" shall be those computation base years, equal in number to the number determined under subparagraph (A), for which the total of his wages and self-employment income is the largest.

(C) For purposes of subparagraph (B), "computation base years" include only calendar years in the period after 1950 and prior to the earlier of the following years—

(i) the year in which occurred (whether by reason of section 202(j) (1) or otherwise) the first month for which the individual was entitled to old-age insurance benefits, or

(ii) the year succeeding the year in which he died.
Any calendar year all of which is included in a period of disability shall not be included as a computation base year.

(3) For purposes of paragraph (2), the number of an individual's elapsed years is the number of calendar years after 1950 (or, if later, the year in which he attained age 21) and [before—

[(A) in the case of a woman, the year in which she died or, if it occurred earlier but after 1960, the year in which she attained age 62,

[(B) in the case of a man who has died, the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 65, or

[(C) in the case of a man who has not died, the year occurring after 1960 in which he attained (or would attain) age 65.

For] *before the year in which he died, or if it occurred earlier but after 1960, the year in which he attained age 62.*¹ For purposes of the preceding sentence, any calendar year any part of which was included in a period of disability shall not be included in such number of calendar years.

(4) The provisions of this subsection shall be applicable only in the case of an individual—

(A) who becomes entitled, after August 1972, to benefits under section 202(a) or section 223; or

(B) who dies after August 1972 without being entitled to benefits under section 202(a) or section 223; or

(C) whose primary insurance amount is required to be recomputed under subsection (f) (2).²

(5) [Repealed.]

Primary Insurance Amount Under Act of March 17, 1971

(c) (1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to September 1972.

(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before September 1972 or who died before such month.³

¹ Applies only in the case of a man who attains (or would attain) age 62 after December 1974. In the case of a man who attains age 62 prior to 1975, the number of elapsed years shall be equal to the number under the law in effect on January 1, 1972, or, if less, the number determined as though he attained age 65 in 1975, except that monthly benefits prior to January 1973 will be determined as though this law had not been enacted.

² P.L. 92-336, sec. 202(a) (3) (B), revised section 215(b) paragraph (4) in its entirety. Effective January 1, 1975, paragraph (4) of section 215(b) will read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

(A) who becomes entitled to benefits under section 202(a) or section 223 in or after the month in which a new table that appears in (or is deemed by subsection (i) (2) (D) to appear in) subsection (a) becomes effective; or

(B) who dies in or after the month in which such table becomes effective without being entitled to benefits under section 202(a) or section 223; or

(C) whose primary insurance amount is required to be recomputed under subsection (f) (2)."

³ P.L. 92-336, sec. 202(a) (3) (C), amended section 215(c) in its entirety. Effective January 1, 1975, section 215(c) will read as follows:

"Primary Insurance Amount Under Prior Provisions.

(c) (1) For the purposes of column II of the latest table that appears in (or is deemed to appear in) subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the month in which the latest such table became effective.

(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223, or who died, before such effective month."

Primary Insurance Benefit Under 1939 Act

(d) (1) For purposes of column I of the table appearing in subsection (a) of this section, an individual's primary insurance benefit shall be computed as follows:

(A) The individual's average monthly wage shall be determined as provided in subsection (b) (but without regard to paragraph (4) thereof) of this section, except that for purposes of paragraph (2) (C) and (3) of such subsection, 1936 shall be used instead of 1950.

(B) For purposes of subparagraphs (B) and (C) of subsection (b) (2), an individual whose total wages prior to 1951 (as defined in subparagraph (C) of this subsection)—

(i) do not exceed \$27,000 shall be deemed to have been paid such wages in equal parts in nine calendar years after 1936 and prior to 1951;

(ii) exceed \$27,000 and are less than \$42,000 shall be deemed to have been paid (I) \$3,000 in each of such number of calendar years after 1936 and prior to 1951 as is equal to the integer derived by dividing such total wages by \$3,000, and (II) the excess of such total wages over the product of \$3,000 times such integer, in an additional calendar year in such period; or

(iii) are at least \$42,000 shall be deemed to have been paid \$3,000 in each of the fourteen calendar years after 1936 and prior to 1951.

(C) For the purposes of subparagraph (B), "total wages prior to 1951" with respect to an individual means the sum of (i) remuneration credited to such individual prior to 1951 on the records of the Secretary, (ii) wages deemed paid prior to 1951 to such individual under section 217, [and] (iii) compensation under the Railroad Retirement Act of 1937 prior to 1951 creditable to him pursuant to this title [], and (iv) wages deemed paid prior to 1951 to such individual under section 231.

(D) The individual's primary insurance benefit shall be 45.6 per centum of the first \$50 of his average monthly wage as computed under this subsection, plus 11.4 per centum of the next \$200 of such average monthly wage.

(2) The provisions of this subsection shall be applicable only in the case of an individual—

(A) with respect to whom at least one of the quarters elapsing prior to 1951 is a quarter of coverage;

(B) except as provided in paragraph (3), who attained age 22 after 1950 and with respect to whom less than six of the quarters elapsing after 1950 are quarters of coverage, or who attained such age before 1951; and

(C) (i) who becomes entitled to benefits under section 202(a) or 223 after the date of the enactment of the Social Security Amendments of 1967, or

(ii) who dies after such date without being entitled to benefits under section 202(a) or 223, or

(iii) whose primary insurance amount is required to be recomputed under section 215(f) (2) or (6), or section 231.

(3) The provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1967 shall be applicable in the case of an individual—

(A) who attained age 21 after 1936 and prior to 1951, or
 (B) who had a period of disability which began prior to 1951,
 but only if the primary insurance amount resulting therefrom is
 higher than the primary insurance amount resulting from the ap-
 plication of this section (as amended by the Social Security
 Amendments of 1967) and section 220.

Certain Wages and Self-Employment Income Not To Be Counted

(e) For the purposes of subsections (b) and (d)—

(1) in computing an individual's average monthly wage there shall not be counted the excess over \$3,600 in the case of any calendar year after 1950 and before 1955, the excess over \$4,200 in the case of any calendar year after 1954 and before 1959, the excess over \$4,800 in the case of any calendar year after 1958 and before 1966, the excess over \$6,600 in the case of any calendar year after 1965 and before 1968, the excess over \$7,800 in the case of any calendar year after 1967 and before 1972, the excess over \$9,000 in the case of any calendar year after 1971 and before 1973, the excess over \$10,800 in the case of any calendar year after 1972 and before 1974, the excess over \$12,000 in the case of any calendar year after 1973 and before 1975, and the excess over an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective of (A) the wages paid to him in such year, plus (B) the self-employment income credited to such year (as determined under section 212); and

(2) if an individual's average monthly wage computed under subsection (b) or for the purposes of subsection (d) is not a multiple of \$1, it shall be reduced to the next lower multiple of \$1.

Recomputation of Benefits

(f)(1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in this subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 217(b).

(2) If an individual has wages or self-employment income for a year after 1965 for any part of which he is entitled to old-age insurance benefits, the Secretary shall, at such time or times and within such period as he may by regulations prescribe, recompute such individual's primary insurance amount with respect to each such year. Such recomputation shall be made as provided in subsections (a)(1)(A) and (C) and (a)(3)¹ as though the year with respect to which such recomputation is made is the last year of the period specified in subsection (b)(2)(C). A recomputation under this paragraph with respect to any year shall be effective—

(A) in the case of an individual who did not die in such year, for monthly benefits beginning with benefits for January of the following year; or

¹ Applies to benefits for months after December 1972 and to lump-sum death payments for deaths after December 1972.

[(B) in the case of an individual who died in such year (including any individual whose increase in his primary insurance amount is attributable to compensation which, upon his death, is treated as remuneration for employment under section 205(o)), for monthly benefits beginning with benefits for the month in which he died.]

(B) in the case of an individual who died in such year, for monthly benefits beginning with benefits for the month in which he died.

(3) In the case of any individual who became entitled to old-age insurance benefits in 1952 or in a taxable year which began in 1952 (and without the application of section 202(j)(1)), or who died in 1952 or in a taxable year which began in 1952 but did not become entitled to such benefits prior to 1952, and who had self-employment income for a taxable year which ended within or with 1952 or which began in 1952, then upon application filed by such individual after the close of such taxable year and prior to January 1961 or (if he died without filing such application and such death occurred prior to January 1961) by a person entitled to monthly benefits on the basis of such individual's wages and self-employment income, the Secretary shall recompute such individual's primary insurance amount. Such recomputation shall be made in the manner provided in the preceding subsections of this section (other than subsection (b)(4)(A)) for computation of such amount, except that (A) the self-employment income closing date shall be the day following the quarter with or within which such taxable year ended, and (B) the self-employment income for any subsequent taxable year shall not be taken into account. Such recomputation shall be effective (A) in the case of an application filed by such individual, for and after the first month in which he became entitled to old-age insurance benefits, and (B) in the case of an application filed by any other person, for and after the month in which such person who filed such application for recomputation became entitled to such monthly benefits. No recomputation under this paragraph pursuant to an application filed after such individual's death shall affect the amount of the lump-sum death payment under subsection (i) of section 202, and no such recomputation shall render erroneous any such payment certified by the Secretary prior to the effective date of the recomputation.

(4) Any recomputation under this subsection shall be effective only if such recomputation results in a higher primary insurance amount.

(5) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained age 65, the Secretary shall recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he died; except that (i) his computation base years referred to in subsection (b)(2) shall include the year in which he died, and (ii) his elapsed years referred to in subsection (b)(3) shall not include the year in which he died or any year thereafter. Such recomputation of such primary insurance amount shall be effective for and after the month in which he died.

(6) *Upon the death after 1967 of an individual entitled to benefits under section 202(a) or section 223, if any person is entitled to monthly benefits or a lump-sum death payment, on the wages and self-employment income of such individual, the Secretary shall recompute the*

decedent's primary insurance amount, but only if the decedent during his lifetime was paid compensation which was treated under section 205(o) as remuneration for employment.

Rounding of Benefits

(g) The amount of any primary insurance amount and the amount of any monthly benefit computed under section 202 or 223 which (after reduction under section 203(a) and deductions under section 203(b)) is not a multiple of \$0.10 shall be raised to the next higher multiple of \$0.10.

(h) (1) Notwithstanding the provisions of subchapter III of chapter 83 of title 5, United States Code, remuneration paid for services to which the provisions of section 210(1) (1) of this Act are applicable and which is performed by an individual as a commissioned officer of the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under this title, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Civil Service Commission certifies to the Secretary that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or, if he has died, to his widow and children, under subchapter III of chapter 83 of title 5, United States Code, on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

Cost-of-Living Increases in Benefits

(i) (1) For purposes of this subsection—

(A) the term "base quarter" means (i) the calendar quarter ending on June 30 in each year after 1972, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this title;

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A) (i), in which the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, such Index in the later of (i) the last prior cost-of-living computation quarter which was established under this subparagraph, or (ii) the most recent calendar quarter in which occurred the effective month of a general benefit increase under this title; except that there shall be no cost-of-living computation quarter in any calendar year in which a law has been enacted providing a general benefit increase under this title or in which such a benefit increase becomes effective; and

(C) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2) (A) (i) The Secretary shall determine each year beginning with 1974 (subject to the limitation in paragraph (1) (B) and to subparagraph (E) of this paragraph) whether the base quarter (as defined in paragraph (1) (A) (i)) in such year is a cost-of-living computation quarter.

(ii) If the Secretary determines that such base quarter is a cost-of-living computation quarter; he shall, effective with the month of January of the next calendar year (subject to subparagraph (E)) as provided in subparagraph (B), increase the benefit amount of each individual who for such month is entitled to benefits under section 227 or 228, and the primary insurance amount of each other individual under this title (*but not including a primary insurance amount determined under subsection (a) (3) of this section*),¹ by an amount derived by multiplying each such amount (including each such individual's primary insurance amount or benefit amount under section 227 or 228 as previously increased under this subparagraph) by the same percentage (rounded to the nearest one-tenth of 1 percent) as the percentage by which the Consumer Price Index for such cost-of-living computation quarter exceeds such index for the most recent prior calendar quarter which was a base quarter under paragraph (1) (A) (ii) or, if later, the most recent cost-of-living computation quarter under paragraph (1) (B). Any such increased amount which is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10.

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply (subject to subparagraph (E)) in the case of monthly benefits under this title for months after December of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after December of such calendar year.

(C) (i) Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1) (A) (ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance.

(ii) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination on or before August 15 of such calendar year, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and

¹ Applies with respect to months after December 1972 and to lump-sum death payments in the case of deaths occurring after such month.

the actuarial assumptions and methodology used in preparing such estimates.

(D) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register on or before November 1 of such calendar year a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at that time (along with the increased benefit amounts which shall be deemed to be the amounts appearing in sections 227 and 228) a revision of the table of benefits contained in subsection (a) of this section (as it may have been most recently revised by another law or pursuant to this paragraph); and such revised table shall be deemed to be the table appearing in such subsection (a). Such revision shall be determined as follows:

(i) The headings of the table shall be the same as the headings in the table immediately prior to its revision, except that the parenthetical phrase at the beginning of column II shall reflect the year in which the primary insurance amounts set forth in column IV of the table immediately prior to its revision were effective.

(ii) The amounts on each line of column I and column III, except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in each such column in the table immediately prior to its revision.

(iii) The amount on each line of column II shall be changed to the amount shown on the corresponding line of column IV of the table immediately prior to its revision.

(iv) The amounts on each line of column IV and column V shall be increased from the amounts shown in the table immediately prior to its revision by increasing each such amount by the percentage specified in subparagraph (A)(ii) of this paragraph. The amount on each line of column V shall be increased, if necessary, so that such amount is at least equal to one and one-half times the amount shown on the corresponding line in column IV. Any such increased amount which is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10.

(v) If the contribution and benefit base (determined under section 230) for the calendar year in which the table of benefits is revised is lower than such base for the following calendar year, columns III, IV, and V of such table shall be extended. The amounts on each additional line of column III shall be the amounts on the preceding line increased by \$5 until in the last such line of column III the second figure is equal to one-twelfth of the new contribution and benefit base for the calendar year following the calendar year in which such table of benefits is revised. The amount on each additional line of column IV shall be the amount on the preceding line increased by \$1.00, until the amount on the last line of such column is equal to the last line of such column as determined under clause (iv) plus 20 percent of one-twelfth of the excess of the new contribution and benefit base for the calendar year following the calendar year in which such table of benefits is revised (as determined under section 230) over such base for the

calendar year in which the table of benefits is revised. The amount in each additional line of column V shall be equal to 1.75 times the amount on the same line of column IV. Any such increased amount which is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10.

(E) Notwithstanding a determination by the Secretary under subparagraph (A) that a base quarter in any calendar year is a cost-of-living computation quarter (and notwithstanding any notification or publication thereof under subparagraph (C) or (D)), no increase in benefits shall take effect pursuant thereto, and such quarter shall be deemed not to be a cost-of-living computation quarter, if during the calendar year in which such determination is made a law providing a general benefit increase under this title is enacted or becomes effective.

(3) As used in this subsection, the term "general benefit increase under this title" means an increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this title are based.

Other Definitions

Sec. 216. For the purposes of this title—

(a) [Repealed.]

Wife

(b) The term "wife" means the wife of an individual, but only if she (1) is the mother of his son or daughter, (2) was married to him for a period of not less than one year immediately preceding the day on which her application is filed, or (3) in the month prior to the month of her marriage to him (A) was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), [or] (h), or (x) of section 202, (B) had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

Widow

(c) The term "widow" (except when used in section 202(i)) means the surviving wife of an individual, but only if (1) she is the mother of his son or daughter, (2) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (3) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (4) she was married to him at the time both of them legally adopted a child under the age of eighteen, (5) she was married to him for a period of not less than nine months immediately prior to the day on which he died, or (6) in the month prior to the month of her marriage to him (A) she was entitled to, or on application therefore and attainment of age 62 in such prior

month would have been entitled to, benefits under subsection (b), (e), [or] (h), or (x) of section 202, (B) she had attained age eighteen and was entitled to, or on application therefore would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) she was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

Divorced Wives; Divorce

(d) (1) The term "divorced wife" means a woman divorced from an individual, but only if she had been married to such individual for a period of 20 years immediately before the date the divorce became effective.

(2) The term "surviving divorced wife" means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 20 years immediately before the date the divorce became effective.

(3) The term "surviving divorced mother" means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18, or (D) she was married to him at the time both of them legally adopted a child under the age of 18.

(4) The terms "divorce" and "divorced" refer to a divorce a vinculo matrimonii.

Child

(e) The term "child" means (1) the child or legally adopted child of an individual, [and] (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) not less than nine months immediately preceding the day on which such individual died, and (3) a person who is the grandchild or stepgrandchild of an individual or his spouse, but only if (A) there was no natural or adoptive parent (other than such a parent who was under a disability, as defined in section 223(d)) of such person living at the time (i) such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (ii) if such individual had a period of disability which continued until such individual became entitled to old-age insurance benefits or disability insurance benefits, or died, at the time such period of disability began, or (B) such person was legally adopted after the death of such individual by such individual's surviving spouse in an adoption that was decreed by a court of competent jurisdiction within the United States and such person's natural or adopting parent or stepparent was not living in such individual's household and making regular contributions toward such person's support at the time such individual died.¹ For

¹ Applies to benefits for months after December 1972, but only on the basis of applications filed on or after date of enactment.

purposes of clause (1), a person shall be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if such person was at the time of such individual's death living in such individual's household and was legally adopted by such individual's surviving spouse after such individual's death but only if (A) proceedings for the adoption of the child had been instituted by such individual before his death, or (B) such child was adopted by such individual's surviving spouse before the end of two years after (i) the day on which such individual died or (ii) the date of enactment of the Social Security Amendments of 1958; except that this sentence shall not apply if at the time of such individual's death such person was receiving regular contributions toward his support from someone other than such individual or his spouse, or from any public or private welfare organization which furnishes services or assistance for children. For purposes of clause (2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, if such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage.

Husband

(f) The term "husband" means the husband of an individual, but only if (1) he is the father of her son or daughter, (2) he was married to her for a period of not less than one year immediately preceding the day on which his application is filed, or (3) in the month prior to the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (f), [or] (h), or (x) of section 202, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) he was entitled to, or upon application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

Widower

(g) The term "widower" (except when used in section 202(i)) means the surviving husband of an individual, but only if (1) he is the father of her son or daughter, (2) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (3) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (4) he was married to her at the time both of them legally adopted a child under the age of eighteen, (5) he was married to her for a period of not less than nine months immediately prior to the day on which she died, or (6) in the month before the month of his marriage to her (A) he was entitled to, or on application there-

for and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (f), [or] (h), or (x) of section 202, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) he was entitled to, or on application therefor and attainment of the required age (if any) he would have been entitled to a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 5 of the Railroad Retirement Act of 1937, as amended.

Determination of Family Status

(h)(1)(A) An applicant is the wife, husband, widow, or widower of a fully or currently insured individual for purposes of this title if the courts of the State in which such insured individual is domiciled at the time such applicant files an application, or, if such insured individual is dead, the courts of the State in which he was domiciled at the time of death, or, if such insured individual is or was not so domiciled in any State, the courts of the District of Columbia, would find that such applicant and such insured individual were validly married at the time such applicant files such application or, if such insured individual is dead, at the time he died. If such courts would not find that such applicant and such insured individual were validly married at such time, such applicant shall, nevertheless be deemed to be the wife, husband, widow, or widower, as the case may be, of such insured individual if such applicant would, under the laws applied by such courts in determining the devolution of intestate personal property, have the same status with respect to the taking of such property as a wife, husband, widow, or widower of such insured individual.

(B) In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual, but it is established to the satisfaction of the Secretary that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage, and such applicant and the insured individual were living in the same household at the time of the death of such insured individual or (if such insured individual is living) at the time such applicant files the application, then, for purposes of subparagraph (A) and subsections (b), (c), (f), and (g), such purported marriage shall be deemed to be a valid marriage. The provisions of the preceding sentence shall not apply (i) if another person is or has been entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual and such other person is (or is deemed to be) a wife, widow, husband, or widower of such insured individual under subparagraph (A) at the time such applicant files the application, or (ii) if the Secretary determines, on the basis of information brought to his attention, that such applicant entered into such purported marriage with

such insured individual with knowledge that it would not be a valid marriage. The entitlement to a monthly benefit under subsection (b), (c), (e), (f), or (g) of section 202, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife, widow, husband, or widower of such insured individual but for this subparagraph, shall end with the month before the month (i) in which the Secretary certifies, pursuant to section 205(i), that another person is entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual, if such other person is (or is deemed to be) the wife, widow, husband, or widower of such insured individual under subparagraph (A), or (ii) if the applicant is entitled to a monthly benefit under subsection (b) or (c) of section 202, in which such applicant entered into a marriage, valid without regard to this subparagraph, with a person other than such insured individual. For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an impediment (i) resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or (ii) resulting from a defect in the procedure followed in connection with such purported marriage.

(2) (A) In determining whether an applicant is the child or parent of a fully or currently insured individual for purposes of this title, the Secretary shall apply such law as would be applied in determining the devolution of intestate personal property by the courts of the State in which such insured individual is domiciled at the time such applicant files application, or, if such insured individual is dead, by the courts of the State in which he was domiciled at the time of his death, or, if such insured individual is or was not so domiciled in any State, by the courts of the District of Columbia. Applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.

(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to be) the child of such insured individual under subparagraph (A), such applicant shall nevertheless be deemed to be the child of such insured individual if such insured individual and the mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1) (B), would have been a valid marriage.

(3) An applicant who is the son or daughter of a fully or currently insured individual, but who is not (and is not deemed to be) the child of such insured individual under paragraph (2), shall nevertheless be deemed to be the child of such insured individual if:

(A) in the case of an insured individual entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits)—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his son or daughter,

(II) has been decreed by a court to be the father of the applicant, or

- (III) has been ordered by a court to contribute to the support of the applicant because the applicant is his son or daughter,
and such acknowledgement, court decree, or court order was made not less than one year before such insured individual became entitled to old-age insurance benefits or attained age 65, whichever is earlier; or
- (ii) such insured individual is shown by evidence satisfactory to the Secretary to be the father of the applicant and was living with or contributing to the support of the applicant at the time such insured individual became entitled to benefits or attained age 65, whichever first occurred;
- (B) in the case of an insured individual entitled to disability insurance benefits, or who was entitled to such benefits in the month preceding the first month for which he was entitled to old-age insurance benefits—
- (i) such insured individual—
- (I) has acknowledged in writing that the applicant is his son or daughter,
- (II) has been decreed by a court to be the father of the applicant, or
- (III) has been ordered by a court to contribute to the support of the applicant because the applicant is his son or daughter,
and such acknowledgement, court decree, or court order was made before such insured individual's most recent period of disability began; or
- (ii) such insured individual is shown by evidence satisfactory to the Secretary to be the father of the applicant and was living with or contributing to the support of that applicant at the time such period of disability began;
- (C) in the case of a deceased individual—
- (i) such insured individual—
- (I) had acknowledged in writing that the applicant is his son or daughter,
- (II) had been decreed by a court to be the father of the applicant, or
- (III) had been ordered by a court to contribute to the support of the applicant because the applicant was his son or daughter,
and such acknowledgment, court decree, or court order was made before the death of such insured individual, or
- (ii) such insured individual is shown by evidence satisfactory to the Secretary to have been the father of the applicant, and such insured individual was living with or contributing to the support of the applicant at the time such insured individual died.

Disability; Period of Disability

- (i) (1) Except for purposes of sections 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable

physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of 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 shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A), (3), (4), and (5) of section 223(d) shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2) (A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than **[6]** *four*¹ full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains the age of 65.

*In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died.*²

(C) A period of disability shall begin—

- (i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or
- (ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the

¹ Section 116(d) of H.R. 1 would strike out "6" and insert in lieu thereof "four", effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act, and for disability determinations under section 216(i) of such act, filed—

(1) in or after the month of enactment, or
(2) before the month of enactment if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before the month of enactment; or

(B) the notice referred to in subparagraph (A) has been so given before the month of enactment, but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act (whether before, in, or after the month of enactment and the decision in such civil action has not become final before the month of enactment;

except that no monthly benefits under title II of the Social Security Act shall be payable or increased by reason of the amendments made by H.R. 1 for months before January 1973.

² Applies in case of deaths occurring after Dec. 31, 1969. Applications with respect to deaths occurring after Dec. 31, 1969, but before the month and year of enactment which is filed in, or within 3 months after the month and year of enactment shall be deemed filed in the month in which such death occurred.

month in which the individual attains age 65, or (ii) the second month following the month in which the disability ceases.

(E) Except as is otherwise provided in subparagraph (F), no application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraphs (B) and (E)) shall be accepted as an application for purposes of this paragraph if—

(i) in the case of an application filed by or on behalf of an individual with respect to a disability which ends after the month in which the Social Security Amendments of 1967 is enacted, such application is filed not more than 36 months after the month in which such disability ended, such individual is alive at the time the application is filed, and the Secretary finds in accordance with regulations prescribed by him that the failure of such individual to file an application for a disability determination within the time specified in subparagraph (E) was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application, and

(ii) in the case of an application filed by or on behalf of an individual with respect to a period of disability which ends in or before the month in which the Social Security Amendments of 1967 is enacted.

(I) such application is filed not more than 12 months after the month in which the Social Security Amendments of 1967 is enacted,

(II) a previous application for a disability determination has been filed by or on behalf of such individual (1) in or before the month in which the Social Security Amendments of 1967 is enacted, and (2) not more than 36 months after the month in which his disability ended, and

(III) the Secretary finds in accordance with regulations prescribed by him, that the failure of such individual to file an application within the then specified time period was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application.

In making a determination under this subsection, with respect to the disability or period of disability of any individual whose application for a determination thereof is accepted solely by reason of the provisions of this subparagraph (F), the provisions of this subsection (other than the provisions of this subparagraph) shall be applied as such provisions are in effect at the time such determination is made.

(G) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application only if the applicant satisfies the requirements for a period

of disability before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed on such first day.

(3) The requirements referred to in clauses (i) and (ii) of paragraph (2) (C) are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 [(if a woman) or age 65 (if a man)]¹ and filed application for benefits under section 202 (a) on the first day of such quarter; and

(B) (i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with such quarter, or

(ii) if such quarter ends before he attains (or would attain) age 31 not less than one-half (and not less than 6) of the quarters during the period ending with such quarter and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage,

[except that the provisions of subparagraph (A) of this paragraph shall not apply in the case of an individual with respect to whom a period of disability would, but for such subparagraph, begin before 1951. For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such numbers shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage.]

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in paragraph (1)).

(4) [Repealed.]

Periods of Limitations Ending on Nonwork Days

(j) Where this title, any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of this title, or any regulation issued by the Secretary pursuant thereto provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is

¹ Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

In the case of a man who attains or will attain age 62 in 1973, the figure "65" shall be deemed to read "64".

In the case of a man who attains or will attain age 62 in 1974, the figure "65" shall be deemed to read "63".

declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Secretary pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this title may (pursuant to section 202(j)(1) or 223(b)) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this title may (pursuant to section 202(j)(2) or 223(b)) be accepted as such.

Waiver of Nine-Month Requirement for Widow, Stepchild, or Widower in Case of Accidental Death or in Case of Serviceman Dying in Line of Duty, or in Case of Remarriage to the Same Individual¹

(k) The requirement in clause (5) of subsection (c) or clause (5) of subsection (g) that the surviving spouse of an individual have been married to such individual for a period of not less than nine months immediately prior to the day on which such individual died in order to qualify as such individual's widow or widower, and the requirement in subsection (e) that the stepchild of a deceased individual have been such stepchild for not less than nine months immediately preceding the day on which such individual died in order to qualify as such individual's child, shall be deemed to be satisfied, where such individual dies within the applicable nine-month period, **[if]** if—

(1) *his death—*

[(1)] (A) *is accidental, or*

[(2)] (B) *occurs in line of duty while he is a member of a uniformed service serving on active duty (as defined in section 210(1)(2)),*

and he would satisfy such requirement if a three-month period were substituted for the nine-month period**[(;)]**, or

(2) (A) *the widow or widower of such individual had been previously married to such individual and subsequently divorced and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce; or*

(B) *the stepchild of such individual had been the stepchild of such individual during a previous marriage of such stepchild's parent to such individual which ended in divorce and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce;*²

except that this subsection shall not apply if the Secretary determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months. For purposes of paragraph (1)(A) of **[the preceding sentence]** *this subsection*, the death of an individual is accidental if he receives bodily injuries solely through violent, external, and accidental means and, as a direct result of the bodily injuries and independently of all other causes, loses his life not later than three months after the day on which he receives such bodily injuries, or in case of remarriage to the same individual.

¹ Applies to benefits for months after December 1972 on the basis of applications filed in or after month of enactment.

² Applies to benefits for months after December 1972 on the basis of applications filed in or after month of enactment.

Benefits in Case of Veterans

Sec. 217. (a) (1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any World War II veteran, and for purposes of section 216(i) (3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of \$160 in each month during any part of which he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality. The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by \$0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i) (3).

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran during World War II, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary of Health, Education, and Welfare shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service during World War II shall, at the

request of the Secretary of Health, Education, and Welfare, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(b) (1) Any World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 215(c). Notwithstanding section 215(d), the primary insurance benefit (for purposes of section 215(c)) of such veteran shall be determined as provided in this title as in effect prior to the enactment of this section, except that the 1 per centum addition provided for in section 209(e)(2) of this Act as in effect prior to the enactment of this section shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Veterans' Administration to be payable by it on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to paragraph (1)(B) of this subsection unless he has been notified by the Veterans' Administration that pension or compensation is determined to be payable by the Veterans' Administration by reason of the death of such veteran. The Secretary of Health, Education, and Welfare shall thereupon report such decision to the Veterans' Administration. If the Veterans' Administration in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, it shall notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payment theretofore certified by the Secretary of Health, Education, and Welfare on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Veterans' Administration, shall (notwithstanding the provisions of section 3101 of title 38, United States Code) be deemed to have been paid to him by such Administration on account of such accrued pension or compensation. No such payment certified by the Secretary of Health, Education, and Welfare, and no payment certified by him for any month prior to the first month for which any pension or compensation is paid by the Veterans' Adminis-

tration shall be deemed by reason of this subsection to have been an erroneous payment.

(c) In the case of any World War II veteran to whom subsection (a) is applicable, proof of support required under section 202(h) may be filed by a parent at any time prior to July 1951 or prior to the expiration of two years after the date of the death of such veteran, whichever is the later.

(d) For the purposes of this section—

(1) The term "World War II" means the period beginning with September 16, 1940, and ending at the close of July 24, 1947.

(2) The term "World War II veteran" means any individual who served in the active military or naval service of the United States at any time during World War II and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(e) (1) For purposes of determining entitlement to and the amount of any monthly benefit or lump-sum death payment payable under this title on the basis of the wages and self-employment income of any veteran (as defined in paragraph (4)), and for purposes of section 216(i) (3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of \$160 in each month during any part of which he served in the active military or naval service of the United States on or after July 25, 1947, and prior to January 1, 1957. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957; is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by \$0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i) (3). In the case of monthly benefits under this title for months after December 1956 (and any lump-sum death payment under this title with respect to a death occurring after December 1956) based on the wages and self-employment income of a veteran who performed

service (as a member of a uniformed service) to which the provisions of section 210(1) (1) are applicable, wages which would, but for the provisions of clause (B), be deemed under this subsection to have been paid to such veteran with respect to his active military or naval service performed after December 1950 shall be deemed to have been paid to him with respect to such service notwithstanding the provisions of such clause, but only if the benefits referred to in such clause which are based (in whole or in part) on such service are payable solely by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey or Public Health Service.

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary of Health, Education, and Welfare shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service on or after July 25, 1947, and prior to January 1, 1957, shall, at the request of the Secretary of Health, Education, and Welfare, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(4) For the purposes of this subsection, the term "veteran" means any individual who served in the active military or naval service of the United States at any time on or after July 25, 1947, and prior to January 1, 1957, and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(f) (1) In any case where a World War II veteran (as defined in subsection (d) (2) or a veteran (as defined in subsection (e) (4)) has died or shall hereafter die, and his widow or child is entitled under subchapter III of chapter 83 of title 5, United States Code, to an annuity in the computation of which his active military or naval service was included, clause (B) of subsection (a) (1) or clause (B)

of subsection (e) (1) shall not operate (solely by reason of such annuity) to make such subsection inapplicable in the case of any monthly benefit under section 202 which is based on his wages and self-employment income; except that no such widow or child shall be entitled under section 202 to any monthly benefit in the computation of which such service is included by reason of this subsection (A) unless such widow or child after December 1956 waives his or her right to receive such annuity, or (B) for any month prior to the first month with respect to which the Civil Service Commission certifies to the Secretary of Health, Education, and Welfare that (by reason of such waiver) no further annuity will be paid to such widow or child under such subchapter III on the basis of such veteran's military or civilian service. Any such waiver shall be irrevocable.

(2) Whenever a widow waives her right to receive such annuity such waiver shall constitute a waiver on her own behalf; a waiver by a legal guardian or guardians, or, in the absence of a legal guardian, the person (or persons) who has the child in his care, of the child's right to receive such annuity shall constitute a waiver on behalf of such child. Such a waiver with respect to an annuity based on a veteran's service shall be valid only if the widow and all children, or, if there is no widow, all the children, waive their rights to receive annuities under subchapter III of chapter 83 of title 5, United States Code, based on such veteran's military or civilian service.

(g) (1) In September 1965, and in every fifth September thereafter up to and including September 2010, the Secretary shall determine the amount which, if paid in equal installments at the beginning of each fiscal year in the period beginning—

(A) with July 1, 1965, in the case of the first such determination, and

(B) with the July 1 following the determination in the case of all other such determinations,

and ending with the close of June 30, 2015, would accumulate, with interest compounded annually, to an amount equal to the amount needed to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of June 30, 2015, as he estimates they would otherwise be in at the close of that date if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted. The rate of interest to be used in determining such amount shall be the rate determined under section 201(d) for public-debt obligations which were or could have been issued for purchase by the Trust Funds in the June preceding the September in which such determination is made.

(2) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund—

(A) for the fiscal year ending June 30, 1966, an amount equal to the amount determined under paragraph (1) in September 1965, and

(B) for each fiscal year in the period beginning with July 1, 1966, and ending with the close of June 30, 2015, an amount equal to the annual installment for such fiscal year under the most recent determination under paragraph (1) which precedes such fiscal year.

(3) For the fiscal year ending June 30, 2016, there is authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position in which they would have been at the close of June 30, 2015, if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted.

(4) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund annually, as benefits under this title and part A of title XVIII are paid after June 30, 2015, such sums as the Secretary determines to be necessary to meet the additional costs resulting from subsections (a), (b), and (e), of such benefits (including lump-sum death payments).

Gratuitous Wage Credits for American Citizens Who Served in the Armed Forces of Allied Countries

(h)(1) For the purposes of this section, any individual who the Secretary finds—

(A) served during World War II (as defined in subsection (d)(1)) in the active military or naval service of a country which was on September 16, 1940, at war with a country with which the United States was at war during World War II;

(B) entered into such active service on or before December 8, 1941;

(C) was a citizen of the United States throughout such period of service or lost his United States citizenship solely because of his entrance into such service;

(D) had resided in the United States for a period or periods aggregating four years during the five-year period ending on the day of, and was domiciled in the United States on the day of, such entrance into such active service; and

(E) (i) was discharged or released from such service under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty, or

(ii) died while in such service, shall be considered a World War II veteran (as defined in subsection (d)(2)) and such service shall be considered to have been performed in the active military or naval service of the United States.

(2) In the case of any individual to whom paragraph (1) applies, proof of support required under section 202 (f) or (h) may be filed at any time prior to the expiration of two years after the date of such individual's death or the date of the enactment of this subsection, whichever is the later.

Voluntary Agreements for Coverage of State and Local Employees

Purpose of Agreement

Sec. 218. (a) (1) The Secretary of Health, Education, and Welfare shall, at the request of any State, enter into an agreement with such State for the purpose of extending the insurance system established

by this title to services performed by individuals as employees of such State or any political subdivision thereof. Each such agreement shall contain such provisions, not inconsistent with the provisions of this section, as the State may request.

(2) Notwithstanding section 210(a), for the purposes of this title the term "employment" includes any service included under an agreement entered into under this section.

Definitions

(b) For the purposes of this section—

(1) The term "State" does not include the District of Columbia, Guam or American Samoa.

(2) The term "political subdivision" includes an instrumentality of (A) a State, (B) one or more political subdivisions of a State, or (C) a State and one or more of its political subdivisions.

(3) The term "employee" includes an officer of a State or political subdivision.

(4) The term "retirement system" means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

(5) The term "coverage group" means (A) employees of the State other than those engaged in performing service in connection with a proprietary function; (B) employees of a political subdivision of a State other than those engaged in performing service in connection with a proprietary function; (C) employees of a State engaged in performing service in connection with a single proprietary function; or (D) employees of a political subdivision of a State engaged in performing service in connection with a single proprietary function. If under the preceding sentence an employee would be included in more than one coverage group by reason of the fact that he performs service in connection with two or more proprietary functions or in connection with both a proprietary function and a nonproprietary function, he shall be included in only one such coverage group. The determination of the coverage group in which such employee shall be included shall be made in such manner as may be specified in the agreement. Civilian employees of National Guard units of a State who are employed pursuant to section 90 of the National Defense Act of June 3, 1916 (32 U.S.C., sec. 42), and paid from funds allotted to such units by the Department of Defense, shall for purposes of this section be deemed to be employees of the State and (notwithstanding the preceding provisions of this paragraph), shall be deemed to be a separate coverage group. For purposes of this section, individuals employed pursuant to an agreement, entered into pursuant to section 205 of the Agricultural Marketing Act of 1946 (7 U.S.C. 1624) or section 14 of the Perishable Agricultural Commodities Act, 1930 (7 U.S.C. 499n), between a State and the United States Department of Agriculture to perform services as inspectors of agricultural products may be deemed, at the option of the State, to be employees of the State and (notwithstanding the preceding provisions of this paragraph) shall be deemed to be a separate coverage group.

Services Covered

(c)(1) An agreement under this section shall be applicable to any one or more coverage groups designated by the State.

(2) In the case of each coverage group to which the agreement applies, the agreement must include all services (other than services excluded by or pursuant to subsection (d) or paragraph (3), (5), or (6) of this subsection) performed by individuals as members of such group.

(3) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any one or more of the following:

(A) All services in any class or classes of (i) elective positions, (ii) part-time positions, or (iii) positions the compensation for which is on a fee basis;

(B) All services performed by individuals as members of a coverage group in positions covered by a retirement system on the date such agreement is made applicable to such coverage group, but only in the case of individuals who, on such date (or, if later, the date on which they first occupy such positions), are not eligible to become members of such system and whose services in such positions have not already been included under such agreement pursuant to subsection (d) (3).

(4) The Secretary of Health, Education, and Welfare shall, at the request of any State, modify the agreement with such State so as to (A) include any coverage group to which the agreement did not previously apply, or (B) include, in the case of any coverage group to which the agreement applies, services previously excluded from the agreement; but the agreement as so modified may not be inconsistent with the provisions of this section applicable in the case of an original agreement with a State. A modification of an agreement pursuant to clause (B) of the preceding sentence may apply to individuals to whom paragraph (3)(B) is applicable (whether or not the previous exclusion of the service of such individuals was pursuant to such paragraph), but only if such individuals are, on the effective date specified in such modification, ineligible to be members of any retirement system or if the modification with respect to such individuals is pursuant to subsection (d) (3).

(5) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any agricultural labor, or service performed by a student, designated by the State. This paragraph shall apply only with respect to service which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section and service the remuneration for which is excluded from wages by paragraph (2) of section 209(h).

(6) Such agreement shall exclude—

(A) service performed by an individual who is employed to relieve him from unemployment,

(B) service performed in a hospital, home, or other institution by a patient or inmate thereof,

(C) covered transportation service (as determined under section 210(k)), and

(D) service (other than agricultural labor or service performed by a student) which is excluded from employment by

any provision of section 210(a) other than paragraph (7) of such section, and

(E) service performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency.

(7) No agreement may be made applicable (either in the original agreement or by any modification thereof) to service performed by any individual to whom paragraph (3)(B) is applicable unless such agreement provides (in the case of each coverage group involved) either that the service of any individual to whom such paragraph is applicable and who is a member of such coverage group shall continue to be covered by such agreement in case he thereafter becomes eligible to be a member of a retirement system, or that such service shall cease to be so covered when he becomes eligible to be a member of such a system (but only if the agreement is not already applicable to such system pursuant to subsection (d)(3)), whichever may be desired by the State.

(8) Notwithstanding any other provision of this section, the agreement with any State entered into under this section may at the option of the State be modified on or after January 1, 1968, to exclude service performed by election officials or election workers if the remuneration paid in a calendar quarter for such service is less than \$50. Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed after an effective date, specified in such modification, which shall not be earlier than the last day of the calendar quarter in which the modification is mailed or delivered by other means to the Secretary.

Positions Covered by Retirement Systems

(d)(1) No agreement with any State may be made applicable (either in the original agreement or by any modification thereof) to any service performed by employees as members of any coverage group in positions covered by a retirement system either (A) on the date such agreement is made applicable to such coverage group, or (B) on the date of enactment of the succeeding paragraph of his subsection (except in the case of positions which are, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of enactment of such succeeding paragraph, no longer covered by a retirement system on the date referred to in clause (A), and except in the case of positions excluded by paragraph (5)(A)). The preceding sentence shall not be applicable to any service performed by an employee as a member of any coverage group in a position (other than a position excluded by paragraph (5)(A)) covered by a retirement system on the date an agreement is made applicable to such coverage group if, on such date (or, if later, the date on which such individual first occupies such position), such individual is ineligible to be a member of such system.

(2) It is hereby declared to be the policy of the Congress in enacting the succeeding paragraphs of this subsection that the protection afforded employees in positions covered by a retirement system on the date an agreement under this section is made applicable to service performed in such positions, or receiving periodic benefits under

such retirement system at such time, will not be impaired as a result of making the agreement so applicable or as a result of legislative enactment in anticipation thereof.

(3) Notwithstanding paragraph (1), an agreement with a State may be made applicable (either in the original agreement or by any modification thereof) to service performed by employees in positions covered by a retirement system (including positions specified in paragraph (4) but not including positions excluded by or pursuant to paragraph (5)), if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary of Health, Education, and Welfare that the following conditions have been met:

(A) A referendum by secret written ballot was held on the question of whether service in positions covered by such retirement system should be excluded from or included under an agreement under this section;

(B) An opportunity to vote in such referendum was given (and was limited) to eligible employees;

(C) Not less than ninety days' notice of such referendum was given to all such employees;

(D) Such referendum was conducted under the supervision of the governor or an agency or individual designated by him: and

(E) A majority of the eligible employees voted in favor of including service in such positions under an agreement under this section.

An employee shall be deemed as "eligible employee" for purposes of any referendum with respect to any retirement system if, at the time such referendum was held, he was in a position covered by such retirement system and was a member of such system, and if he was in such a position at the time notice of such referendum was given as required by clause (C) of the preceding sentence; except that he shall not be deemed an "eligible employee" if, at the time the referendum was held, he was in a position to which the State agreement already applied, or if he was in a position excluded by or pursuant to paragraph (5). No referendum with respect to a retirement system shall be valid for purposes of this paragraph unless held within the two-year period which ends on the date of execution of the agreement or modification which extends the insurance system established by this title to such retirement system, nor shall any referendum with respect to a retirement system be valid for purposes of this paragraph if held less than one year after the last previous referendum held with respect to such retirement system.

(4) For the purposes of subsection (c) of this section, the following employees shall be deemed to be a separate coverage group—

(A) all employees in positions which were covered by the same retirement system on the date the agreement was made applicable to such system (other than employees to whose services the agreement already applied on such date);

(B) all employees in positions which became covered by such system at any time after such date; and

(C) all employees in positions which were covered by such system at any time before such date and to whose services the

insurance system established by this title has not been extended before such date because the positions were covered by such retirement system (including employees to whose services the agreement was not applicable on such date because such services were excluded pursuant to subsection (c)(3)(B)).

(5)(A) Nothing in paragraph (3) of this subsection shall authorize the extension of the insurance system established by this title to service in any policeman's or fireman's position.

(B) At the request of the State, any class or classes of positions covered by a retirement system which may be excluded from the agreement pursuant to paragraph (3) or (5) of subsection (c), and to which the agreement does not already apply, may be excluded from the agreement at the time it is made applicable to such retirement system; except that, notwithstanding the provisions of paragraph (3)(B) of such subsection, such exclusion may not include any services to which such paragraph (3)(B) is applicable. In the case of any such exclusion, each such class so excluded shall, for purposes of this subsection, constitute a separate retirement system in case of any modification of the agreement thereafter agreed to.

(6)(A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisions of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of a State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (f) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

(B) If a retirement system covers positions of employees of one or more institutions of higher learning, then, for purposes of such preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of each such institution of higher learning. For the purposes of this subparagraph, the term "institutions of higher learning" includes junior colleges and teachers colleges. If a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of the preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

(C) For the purposes of this subsection, any retirement system established by the State of Alaska, California, Connecticut, Florida,

Georgia, Illinois, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, Wisconsin, or Hawaii, or any political subdivision of any such State, which, on, before, or after the date of enactment of this subparagraph, is divided into two divisions or parts, one of which is composed of positions of members of such system who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who do not desire such coverage, shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring such coverage the positions of individuals who become members of such system after such coverage is extended, be deemed to be a separate retirement system with respect to each such division or part. If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under an agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the positions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agreement under this section, and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph.

(D) (i) The position of any individual which is covered by any retirement system to which subparagraph (C) is applicable shall, if such individual is ineligible to become a member of such system on August 1, 1956, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title.

(ii) Notwithstanding clause (i), the State may, pursuant to subsection (c)(4)(B) and subject to the conditions of continuation or termination of coverage provided for in subsection (c)(7), modify its agreement under this section to include services performed by all individuals described in clause (i) other than those individuals to whose services the agreement already applies. Such individuals shall be deemed (on and after the effective date of the modification) to be in positions covered by the separate retirement system consisting of the positions of members of the division or part who desire coverage under the insurance system established under this title.

(E) An individual who is in a position covered by a retirement system to which subparagraph (C) is applicable and who is not a member of such system but is eligible to become a member thereof

shall, for purposes of this subsection (other than paragraph (8)), be regarded as a member of such system; except that, in the case of any retirement system a division or part of which is covered under the agreement (either in the original agreement or by a modification thereof), which coverage is agreed to prior to 1960, the preceding provisions of this subparagraph shall apply only if the State so requests and any such individual referred to in such preceding provisions shall, if the State so requests, be treated, after division of the retirement system pursuant to such subparagraph (C), the same as individuals in positions referred to in subparagraph (F).

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Secretary prior to 1970 or, if later, the expiration of two years after the date on which such agreement, or the modification thereof making the agreement applicable to such separate retirement system, as the case may be, is agreed to, but only if, prior to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection (f) (1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

(G) For the purposes of this subsection, in the case of any retirement system of the State of Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, or Hawaii which covers positions of employees of such State who are compensated in whole or in part from grants made to such State under title III, there shall be deemed to be, if such State so desires, a separate retirement system with respect to any of the following:

- (i) the positions of such employees;
- (ii) the positions of all employees of such State covered by such retirement system who are employed in the department of such State in which the employees referred to in clause (i) are employed; or
- (iii) employees of such State covered by such retirement system who are employed in such department of such State in positions other than those referred to in clause (i).

(7) The certification by the governor (or an official of the State designated by him for the purpose) required under paragraph (3) shall be deemed to have been made, in the case of a division or part (created under subparagraph (C) of paragraph (6) or the corresponding provision of prior law) consisting of the positions of members of a retirement system who desire coverage under the agreement under this section, if the governor (or the official so designated) certifies to the Secretary of Health, Education, and Welfare that—

(A) an opportunity to vote by written ballot on the question of whether they wish to be covered under an agreement under this section was given to all individuals who were members of such system at the time the vote was held;

(B) not less than ninety days' notice of such vote was given to all individuals who were members of such system on the date the notice was issued;

(C) the vote was conducted under the supervision of the governor or an agency or individual designated by him; and

(D) such system was divided into two parts or divisions in accordance with the provisions of subparagraphs (C) and (D) of paragraph (6) or the corresponding provision of prior law.

For purposes of this paragraph, an individual in a position to which the State agreement already applied or in a position excluded by or pursuant to paragraph (5) shall not be considered a member of the retirement system.

(8) (A) Notwithstanding paragraph (1), if under the provisions of this subsection an agreement is, after December 31, 1958, made applicable to service performed in positions covered by a retirement system, service performed by an individual in a position covered by such a system may not be excluded from the agreement because such position is also covered under another retirement system.

(B) Subparagraph (A) shall not apply to service performed by an individual in a position covered under a retirement system if such individual, on the day the agreement is made applicable to service performed in positions covered by such retirement system, is not a member of such system and is a member of another system.

(C) If an agreement is made applicable, prior to 1959, to service in positions covered by any retirement system, the preceding provisions of this paragraph shall be applicable in the case of such system if the agreement is modified to so provide.

(D) Except in the case of agreements with the States named in subsection (p) and agreements with interstate instrumentalities, nothing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

Payments and Reports by States

(e) (1) Each agreement under this section shall provide—

(A) that the State will pay to the Secretary of the Treasury, at such time or times as the Secretary of Health, Education, and Welfare may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if the services of employees covered by the agreement constituted employment as defined in section 3121 of such code; and

(B) that the State will comply with such regulations relating to payments and reports as the Secretary of Health, Education, and Welfare may prescribe to carry out the purposes of this section.

(2) Where—

(A) an individual in any calendar year performs services to which an agreement under this section is applicable (i) as the

employee of two or more political subdivisions of a State or (ii) as the employee of a State and one or more political subdivisions of such State; and

(B) such State provides all of the funds for the payment of those amounts referred to in paragraph (1) (A) which are equivalent to the taxes imposed by section 3111 of the Internal Revenue Code of 1954 with respect to wages paid to such individual for such services; and

(C) the political subdivision or subdivisions involved do not reimburse such State for the payment of such amounts or, in the case of services described in subparagraph (A) (ii), for the payment of so much of such amounts as is attributable to employment by such subdivision or subdivisions;

then, notwithstanding paragraph (1), the agreement under this section with such State may provide (either in the original agreement or by a modification thereof) that the amounts referred to in paragraph (1) (A) may be computed as though the wages paid to such individual for the services referred to in clause (A) of this paragraph were paid by one political subdivision for services performed in its employ; but the provisions of this paragraph shall be applicable only where such State complies with such regulations as the Secretary may prescribe to carry out the purposes of this paragraph. The preceding sentence shall be applicable with respect to wages paid after an effective date specified in such agreement or modification, but in no event with respect to wages paid before (i) January 1, 1957, in the case of an agreement or modification which is mailed or delivered by other means to the Secretary before January 1, 1962, or (ii) the first day of the year in which the agreement or modification is mailed or delivered by other means to the Secretary, in the case of an agreement or modification which is so mailed or delivered on or after January 1, 1962.

Effective Date of Agreement

(f) (1) Except as provided in subsection (e) (2), any agreement or modification of an agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is agreed to by the Secretary and the State.

(2) In the case of service performed by members of any coverage group—

(A) to which an agreement under this section is made applicable, and

(B) with respect to which the agreement, or modification thereof making the agreement so applicable, specifies an effective date earlier than the date of execution of such agreement and such modification, respectively,

the agreement shall, if so requested by the State, be applicable to such services (to the extent the agreement was not already applicable) performed before such date of execution and after such effective date by any individual as a member of such coverage group if he is such a member on a date, specified by the State, which is earlier than such

date of execution, except that in no case may the date so specified be earlier than the date such agreement or such modification, as the case may be, is mailed, or delivered by other means, to the Secretary.

(3) Notwithstanding the provisions of paragraph (2) of this subsection, in the case of services performed by individuals as members of any coverage group to which an agreement under this section is made applicable, and with respect to which there were timely paid in good faith to the Secretary of the Treasury amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 had such services constituted employment for purposes of chapter 21 of such Code at the time they were performed, and with respect to which refunds were not obtained, such individuals may, if so requested by the State, be deemed to be members of such coverage group on the date designated pursuant to paragraph (2).

Termination of Agreement

(g) (1) Upon giving at least two years' advance notice in writing to the Secretary of Health, Education, and Welfare, a State may terminate, effective at the end of a calendar quarter specified in the notice, its agreement with Secretary [either]—

(A) in its entirety but only if the agreement has been in effect from its effective date for not less than five years prior to the receipt of such notice; or

(B) with respect to any coverage group designated by the State, but only if the agreement has been in effect with respect to such coverage group for not less than five years prior to the receipt of such notice[.]; or

(C) *with respect to services of—*

(i) all employees included under the agreement as a single coverage group within the meaning of subsection (d) (4) which is composed entirely of positions of policemen or firemen or both;

(ii) all employees in positions of policemen or firemen or both which are included under the agreement as a part of a coverage group within the meaning of subsection (d) (4); or

(iii) all employees in positions of policemen or firemen or both which were included under the agreement as a part of a coverage group as defined in subsection (b) (5) and which were covered by a retirement system after the date coverage was extended to such group,

but only if the agreement has been in effect with respect to employees in such positions for not less than five years prior to the receipt of such notice.

(2) If the Secretary, after reasonable notice and opportunity for hearing to a State with whom he has entered into an agreement pursuant to this section, finds that the State has failed or is no longer legally able to comply substantially with any provision of such agreement or of this section, he shall notify such State that the agreement will be terminated in its entirety, or with respect to any one or more coverage groups designated by him, at such time, not later than two years from the date of such notice, as he deems appropriate, unless

prior to such time he finds that there no longer is any such failure or that the cause for such legal inability has been removed.

(3) If any agreement entered into under this section is terminated in its entirety, the Secretary and the State may not again enter into an agreement pursuant to this section. If any such agreement is terminated with respect to any coverage group, the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such coverage group. *If any such agreement is terminated with respect to services of employees in positions of policemen or firemen as described in paragraph (1)(C), the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable to services performed by employees in such positions.*

Deposits in Trust Fund; Adjustments

(h)(1) All amounts received by the Secretary of the Treasury under an agreement made pursuant to this section shall be deposited in the Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a) (3) of section 201, subsection (b) (1) of such section, and subsection (a) (1) of section 1817, respectively.

(2) If more or less than the correct amount due under an agreement made pursuant to this section is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be prescribed by regulations of the Secretary of Health, Education, and Welfare.

(3) If an overpayment cannot be adjusted under paragraph (2), the amount thereof and the time or times it is to be paid shall be certified by the Secretary of Health, Education, and Welfare to the Managing Trustee, and the Managing Trustee, through the Fiscal Service of the Treasury Department and prior to any action thereon by the General Accounting Office, shall make payment in accordance with such certification. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary of Health, Education, and Welfare.

Regulations

(i) Regulations of the Secretary of Health, Education, and Welfare to carry out the purposes of this section shall be designed to make the requirements imposed on States pursuant to this section the same, so far as practicable, as those imposed on employers pursuant to this title and chapter 21 and subtitle F of the Internal Revenue Code of 1954.

Failure To Make Payments

(j) In case any State does not make, at the time or times due, the payments provided for under an agreement pursuant to this section there shall be added, as part of the amounts due, interest at the rate of 6 per centum per annum from the date due until paid, and the Secretary of Health, Education, and Welfare may, in his discretion, deduct such amounts plus interest from any amounts certified by him to the

Secretary of the Treasury for payment to such State under any other provision of this Act. Amounts so deducted shall be deemed to have been paid to the State under such other provision of this Act. Amounts equal to the amounts deducted under this subsection are hereby appropriated to the Trust Funds in the ratio in which amounts are deposited in such Funds pursuant to subsection (h) (1).

Instrumentalities of Two or More States

(k) (1) The Secretary of Health, Education, and Welfare may, at the request of any instrumentality of two or more States, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such instrumentality. Such agreement, to the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

(2) In the case of any instrumentality of two or more States, if—

(A) employees of such instrumentality are in positions covered by a retirement system of such instrumentality or of any of such States or any of the political subdivisions thereof, and

(B) such retirement system is (on, before, or after the date of enactment of this paragraph) divided into two divisions or parts, one of which is composed of positions of members of such system who are employees of such instrumentality and who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who are employees of such instrumentality and who do not desire such coverage, and

(C) it is provided that there shall be included in such division or part composed of the positions of members desiring such coverage the positions of employees of such instrumentality who become members of such system after such coverage is extended, then such retirement system shall, if such instrumentality so desires, be deemed to be a separate retirement system with respect to each such division or part. An individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection, be regarded as a member of such system. Coverage under the agreement of any such individual shall be provided under the same conditions, to the extent practicable, as are applicable in the case of the States to which the provisions of subsection (d) (6) (C) apply. The position of any employee of any such instrumentality which is covered by any retirement system to which the first sentence of this paragraph is applicable shall, if such individual is ineligible to become a member of such system on the date of enactment of this paragraph or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title. Services in positions covered by a separate retirement system created pursuant to this subsection (and consisting of the positions of members who desire coverage under an agreement under this section) shall be covered under such agreement

on compliance, to the extent practicable, with the same conditions as are applicable to coverage under an agreement under this section of services in positions covered by a separate retirement system created pursuant to subparagraph (C) of subsection (d)(6) or the corresponding provision of prior law (and consisting of the positions of members who desire coverage under such agreement).

(3) Any agreement with any instrumentality of two or more States entered into pursuant to this Act may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), apply to service performed by employees of such instrumentality in any policeman's or fireman's position covered by a retirement system, but only upon compliance, to the extent practicable, with the requirements of subsection (d)(3). For the purpose of the preceding sentence, a retirement system which covers positions of policemen or firemen or both, and other positions shall, if the instrumentality concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Delegation of Functions

(1) The Secretary of Health, Education, and Welfare is authorized pursuant to agreement with the head of any Federal agency, to delegate any of his functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

Wisconsin Retirement Fund

(m)(1) Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provisions of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund.

(2) All employees in positions covered by the Wisconsin retirement fund at any time on or after January 1, 1951, shall, for the purposes of subsection (c) only, be deemed to be a separate coverage group; except that there shall be excluded from such separate coverage group all employees in positions to which the agreement applies without regard to this subsection.

(3) The modification pursuant to this subsection shall exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) service performed by any individual during any period before he is included under the Wisconsin retirement fund.

(4) The modification pursuant to this subsection shall, if the State of Wisconsin requests it, exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) all service performed in policemen's positions, all service performed in firemen's positions, or both.

Certain Positions No Longer Covered by Retirement Systems

(n) Notwithstanding subsection (d), an agreement with any State entered into under this section prior to the date of the enactment of this subsection may, prior to January 1, 1958, be modified pursuant

to subsection (c) (4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on such date of enactment), in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of the enactment of this subsection, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

Certain Employees of the State of Utah

(o) Notwithstanding the provisions of subsection (d), the agreement with the State of Utah entered into pursuant to this section may be modified pursuant to subsection (c) (4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any of such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950.

Policemen and Firemen in Certain States

(p) (1) Any agreement with the State of Alabama, California, Florida, Georgia, Hawaii, *Idaho*, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, or Washington entered into pursuant to this section prior to the date of enactment of this subsection may, notwithstanding the provisions of subsection (d) (5) (A) and the references thereto in subsections (d) (1) and (d) (3), be modified pursuant to subsection (c) (4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after the date of the enactment of this subsection, but only upon compliance with the requirements of subsection (d) (3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

(2) A State, not otherwise listed by name in paragraph (1), shall be deemed to be a State listed in such paragraph for the purpose of extending coverage under this title to service in firemen's positions covered by a retirement system, if the Governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary of Health, Education, and Welfare that the overall benefit

protection of the employees in such positions would be improved by reason of the extension of such coverage to such employees. Notwithstanding the provisions of the second sentence of such paragraph (1), such firemen's positions shall be deemed a separate retirement system and no other positions shall be included in such system.

Time Limitation on Assessments

(q) (1) Where a State is liable for an amount due under an agreement pursuant to this section, such State shall remain so liable until the Secretary is satisfied that the amount due has been paid to the Secretary of the Treasury.

(2) Notwithstanding paragraph (1), a State shall not be liable for an amount due under an agreement pursuant to this section, with respect to the wages paid to individuals, after the expiration of the latest of the following periods—

(A) three years, three months, and fifteen days after the year in which such wages were paid, or

(B) three years after the date on which such amount became due, or

(C) three years, three months, and fifteen days after the year following the year in which this subsection is enacted, unless prior to the expiration of such period the Secretary makes an assessment of the amount due.

(3) For purposes of this subsection and section 205(c), an assessment of an amount due is made when the Secretary mails or otherwise delivers to the State a notice stating the amount he has determined to be due under an agreement pursuant to this section and the basis for such determination.

(4) An assessment of an amount due made by the Secretary after the expiration of the period specified in paragraph (2) shall nevertheless be deemed to have been made within such period if—

(A) before the expiration of such period (or, if it has previously been extended under this paragraph, of such period as so extended), the State and the Secretary agree in writing to an extension of such period (or extended period) and, subject to such conditions as may be agreed upon, the Secretary makes the assessment prior to the expiration of such extension; or

(B) within the 365 days immediately preceding the expiration of such period (or extended period) the State pays to the Secretary of the Treasury less than the correct amount due under an agreement pursuant to this section with respect to wages paid to individuals in any calendar quarters as members of a coverage group, and the Secretary of Health, Education, and Welfare makes the assessment, adjusted to take into account the amount paid by the State, no later than the 365th day after the day the State made payment to the Secretary of the Treasury; but the Secretary of Health, Education, and Welfare shall make such assessment only with respect to the wages paid to such individuals in such calendar quarters as members of such coverage group; or

(C) pursuant to subparagraph (A) or (B) of section 205(c)(5) he includes in his records an entry with respect to wages for an

individual, but only if such assessment is limited to the amount due with respect to such wages and is made within the period such entry could be made in such records under such subparagraph.

(5) If the Secretary allows a claim for a credit or refund of an overpayment by a State under an agreement pursuant to this section, with respect to wages paid or alleged to have been paid to an individual in a calendar year for services as a member of a coverage group, and if as a result of the facts on which such allowance is based there is an amount due from the State, with respect to wages paid to such individual in such calendar year for services performed as a member of a coverage group, for which amount the State is not liable by reason of paragraph (2) then notwithstanding paragraph (2) the State shall be liable for such amount due if the Secretary makes an assessment of such amount due at the time of or prior to notification to the State of the allowance of such claim. For purposes of this paragraph and paragraph (6), interest as provided for in subsection (j) shall not be included in determining the amount due.

(6) The Secretary shall accept wage reports filed by a State under an agreement pursuant to this section or regulations of the Secretary thereunder, after the expiration of the period specified in paragraph (2) or such period as extended pursuant to paragraph (4), with respect to wages which are paid to individuals performing services as employees in a coverage group included in the agreement and for payment in connection with which the State is not liable by reasons of paragraph (2), only if the State—

(A) pays to the Secretary of the Treasury the amount due under such agreement with respect to such wages, and

(B) agrees in writing with the Secretary of Health, Education, and Welfare to an extension of the period specified in paragraph (2) with respect to wages paid to all individuals performing services as employees in such coverage group in the calendar quarters designated by the State in such wage reports as the periods in which such wages were paid. If the State so agrees, the period specified in paragraph (2), or such period as extended pursuant to paragraph (4), shall be extended until such time as the Secretary notifies the State that such wage reports have been accepted.

(7) Notwithstanding the preceding provisions of this subsection, where there is an amount due by a State under an agreement pursuant to this section and there has been a fraudulent attempt on the part of an officer or employee of the State or any political subdivision thereof to defeat or evade payment of such amount due, the State shall be liable for such amount due without regard to the provisions of paragraph (2), and the Secretary may make an assessment of such amount due at any time.

Time Limitations on Credits and Refunds

(r)(1) No credit or refund of an overpayment by a State under an agreement pursuant to this section with respect to wages paid or alleged to have been paid to an individual as a member of a coverage

group in a calendar quarter shall be allowed after the expiration of the latest of the following periods—

(A) three years, three months, and fifteen days after the year in which occurred the calendar quarter in which such wages were paid or alleged to have been paid, or

(B) three years after the date the payment which included such overpayment became due under such agreement with respect to the wages paid or alleged to have been paid to such individual as a member of such coverage group in such calendar quarter, or

(C) two years after such overpayment was made to the Secretary of the Treasury, or

(D) three years, three months, and fifteen days after the year following the year in which this subsection is enacted,

unless prior to the expiration of such period a claim for such credit or refund is filed with the Secretary of Health, Education, and Welfare by the State.

(2) A claim for a credit or refund filed by a State after the expiration of the period specified by paragraph (1) shall nevertheless be deemed to have been filed within such period if—

(A) before the expiration of such period (or, if it has previously been extended under this subparagraph, of such period as so extended) the State and the Secretary agreed in writing to an extension of such period (or extended period) and the claim is filed with the Secretary by the State prior to the expiration of such extension; but any claim for a credit or refund valid because of this subparagraph shall be allowed only to the extent authorized by the conditions provided for in the agreement for such extension, or

(B) the Secretary deletes from his records an entry with respect to wages of an individual pursuant to the provisions of subparagraph (A), (B), or (E) of section 205(c)(5), but only with respect to the entry so deleted.

Review by Secretary

(s) Where the Secretary has made an assessment of an amount due by a State under an agreement pursuant to this section, disallowed a State's claim for a credit or refund of an overpayment under such agreement, or allowed a State a credit or refund of an overpayment under such agreement, he shall review such assessment, disallowance, or allowance if a written request for such review is filed with him by the State within 90 days (or within such further time as he may allow) after notification to the State of such assessment, disallowance, or allowance. On the basis of the evidence obtained by or submitted to the Secretary, he shall render a decision affirming, modifying, or reversing such assessment, disallowance, or allowance. In notifying the State of his decision, the Secretary shall state the basis therefor.

Review by Court

(t) (1) Notwithstanding any other provision of this title any State, irrespective of the amount in controversy, may file, within two years after the mailing to such State of the notice of any decision by the Secretary pursuant to subsection (s) affecting such State, or within

such further time as the Secretary may allow, a civil action for a re-determination of the correctness of the assessment of the amount due, the disallowance of the claim for a refund or credit, or the allowance of the refund or credit, as the case may be, with respect to which the Secretary has rendered such decision. Such action shall be brought in the district court of the United States for the judicial district in which is located the capital of such State, or, if such action is brought by an instrumentality of two or more States, the principal office of such instrumentality. The judgment of the court shall be final, except that it shall be subject to review in the same manner as judgments of such court in other civil actions. Any action filed under this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(2) Notwithstanding the provisions of section 2411 of title 28, United States Code, no interest shall accrue to a State after final judgment with respect to a credit or refund of an overpayment made under an agreement pursuant to this section.

(3) The first sentence of section 2414 of title 28, United States Code, shall not apply to final judgments rendered by district courts of the United States in civil actions filed under this subsection. In such cases, the payment of amounts due to States pursuant to such final judgments shall be adjusted in accordance with the provisions of this section and with regulations promulgated by the Secretary.

Positions Compensated Solely on a Fee Basis

(u)(1) Notwithstanding any other provision in this section, an agreement entered into under this section may be made applicable to service performed after 1967 in any class or classes of positions compensated solely on a fee basis to which such agreement did not apply prior to 1968 only if the State specifically requests that its agreement be made applicable to such service in such class or classes of positions.

(2) Notwithstanding any other provision in this section, an agreement entered into under this section may be modified, at the option of the State, at any time after 1967, so as to exclude services performed in any class or classes of positions compensation for which is solely on a fee basis.

(3) Any modification made under this subsection shall be effective with respect to services performed after the last day of the calendar year in which the modification is agreed to by the Secretary and the State.

(4) If any class or classes of positions have been excluded from coverage under the State agreement by a modification agreed to under this subsection, the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such class or classes of positions.

Sec. 219. [Repealed.]

Disability Provisions Inapplicable if Benefit Rights Impaired

Sec. 220. None of the provisions of this title relating to periods of disability shall apply in any case in which their application would result in the denial of monthly benefits or a lump-sum death payment

which would otherwise be payable under this title; nor shall they apply in the case of any monthly benefit or lump-sum death payment under this title if such benefit or payment would be greater without their application.

Disability Determinations

Sec. 221. (a) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 216(i) or 223(d)) and of the day such disability began, and the determination of the day on which such disability ceases, shall, except as provided in subsection (g), be made by a State agency pursuant to an agreement entered into under subsection (b). Except as provided in subsection (c) and (d), any such determinations shall be the determination of the Secretary for purposes of this title.

(b) The Secretary shall enter into an agreement with each State which is willing to make such an agreement under which the State agency or agencies administering the State plan approved under the Vocational Rehabilitation Act, or any other appropriate State agency or agencies, or both, will make the determinations referred to in subsection (a) with respect to all individuals in such State, or with respect to such class or classes of individuals in the State as may be designated in the agreement at the State's request.

(c) The Secretary may on his own motion review a determination, made by a State agency pursuant to an agreement under this section, that an individual is under a disability (as defined in section 216(i) or 223(d)) and, as a result of such review, may determine that such individual is not under a disability (as so defined) or that such disability began on a day later than that determined by such agency, or that such disability ceased on a day earlier than that determined by such agency.

(d) Any individual dissatisfied with any determination under subsection (a), (c), or (g) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(e) Each State which has an agreement with the Secretary under this section shall be entitled to receive from the Trust Funds, in advance or by way of reimbursement, as may be mutually agreed upon, the cost to the State of carrying out the agreement under this section. The Secretary shall from time to time certify such amount as is necessary for this purpose to the Managing Trustee, reduced or increased, as the case may be, by any sum (for which adjustment hereunder has not previously been made) by which the amount certified for any prior period was greater or less than the amount which should have been paid to the State under this subsection for such period; and the Managing Trustee, prior to audit or settlement by the General Accounting Office, shall make payment from the Trust Funds at the time or times fixed by the Secretary, in accordance with such certification. Appropriate adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to the payments made under this subsection shall

be made in accordance with paragraph (1) of subsection (g) of section 201 (but taking into account any refunds under subsection (f) of this section) to insure that the Federal Disability Trust Fund is charged with all expenses incurred which are attributable to the administration of section 223 and the Federal Old-Age and Survivors Insurance Trust Fund is charged with all other expenses.

(f) All money paid to a State under this section shall be used solely for the purposes for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Funds.

(g) In the case of individuals in a State which has no agreement under subsection (b), in the case of individuals outside the United States, and in the case of any class or classes of individuals not included in an agreement under subsection (b), the determinations referred to in subsection (a) shall be made by the Secretary in accordance with regulations prescribed by him.

Rehabilitation Services

Referral for Rehabilitation Services

Sec. 222. (a) It is hereby declared to be the policy of the Congress that disabled individuals applying for a determination of disability, and disabled individuals who are entitled to child's insurance benefits, widow's insurance benefits, or widower's insurance benefits, shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.

Deduction on Account of Refusal To Accept Rehabilitation Services

(b) (1) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefit or benefits under sections 202 and 223 for any month in which such individual, if a child who has attained the age of eighteen and is entitled to child's insurance benefits, a widow, *widower* or surviving divorced wife who has not attained age 60, [a widower who has not attained age 62,]¹ or an individual entitled to disability insurance benefits, (*other than such an individual whose disability is blindness, as defined in section 216(i)(1)(B)*), refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act. Any individual who is a member or adherent of any recognized church or religious sect which teaches its member or adherents to rely solely, in the treatment and cure of any physical or mental impairment, upon prayer or spiritual means through the application and use of the tenets or teachings of such church or sect, and

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

who, solely because of his adherence to the teachings or tenets of such church, or sect, refuses to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act, shall, for the purposes of the first sentence of this subsection, be deemed to have done so with good cause.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled or from any mother's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or such mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual who is entitled to disability insurance benefits and in which such individual refuses to accept rehabilitation services and a deduction, on account of such refusal, is imposed under paragraph (1). If both this paragraph and paragraph (3) are applicable to a child's insurance benefit for any month, only an amount equal to such benefit shall be deducted.

(3) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to disability insurance benefits, to which a wife, divorced wife, husband, or child is entitled, until the total of such deductions equal such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which the individual, on the basis of whose wages and self-employment income such benefit was payable, refuses to accept rehabilitation services and deductions, on account of such refusal, are imposed under paragraph (1).

(4) The provisions of paragraph (1) shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).

Period of Trial Work

(c) (1) The term "period of trial work", with respect to an individual entitled to benefits under section 223 or 202(d), means a period of months beginning and ending as provided in paragraphs (3) and (4).

(2) For purposes of sections 216(i) and 223, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 202(d) who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following the month in which this paragraph is enacted; and no such period may begin for an individual in

a period of disability of such individual in which he had a previous period of trial work.

(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(A) the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

(B) the month in which his disability (as defined in section 223(d)) ceases (as determined after application of paragraph (2) of this subsection).

(5) In the case of an individual who becomes entitled to benefits under section 223 for any month as provided in clause (ii) of subsection (a)(1) of such section, the preceding provisions of this subsection shall not apply with respect to services in any month beginning with the first month for which he is so entitled and ending with the first month thereafter for which he is not entitled to benefits under section 223.

Costs of Rehabilitation Services From Trust Funds

(d)(1) For the purpose of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 223, or

(B) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability), or

(C) entitled to widow's insurance benefits under section 202(e) prior to attaining age 60, or

(D) entitled to widower's insurance benefits under section 202(f) prior to attaining age ~~62~~ 60,¹ to the end that savings will result to the Trust Fund as a result of rehabilitating the maximum number of such individuals into productive activity, there are authorized to be transferred from the Trust Funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals (including (i) services during their waiting periods, and (ii) so much of the expenditures for the administration of any State plan as is attributable to carrying out this subsection); except that the total amount so made available pursuant to this subsection [in any fiscal year may not exceed 1 percent of the total of the benefits under section 202(d) for children who have attained age 18 and are under a disability] *may not exceed—*

(i) 1 percent in the fiscal year ending June 30, 1972,

(ii) 1.25 percent in the fiscal year ending June 30, 1973,

(iii) 1.5 percent in the fiscal year ending June 30, 1974, and

thereafter,

of the total of the benefits under section 202(d) for children who have attained age 18 and are under a disability, the benefits under section 202(e) for widows and surviving divorced wives who have not attained age 60 and are under a disability, the benefits under

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case of an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

section 202(f) for widowers who have not attained age [62] 60, and the benefits under section 223, which were certified for payment in the preceding year. The selection of individuals (including the order in which they shall be selected) to receive such services shall be made in accordance with criteria formulated by the Secretary which are based upon the effect the provision of such services would have upon the Trust Funds.

(2) In the case of each State which is willing to do so, such vocational rehabilitation services shall be furnished under a State plan for vocational rehabilitation services which—

(A) has been approved under section 5 of the Vocational Rehabilitation Act,

(B) provides that, to the extent funds provided under this subsection are adequate for the purpose, such services will be furnished, to any individual in the State who meets the criteria prescribed by the Secretary pursuant to paragraph (1), with reasonable promptness and in accordance with the order of selection determined under such criteria, and

(C) provides that such services will be furnished to any individual without regard to (i) his citizenship or place of residence, (ii) his need for financial assistance except as provided in regulations of the Secretary in the case of maintenance during rehabilitation, or (iii) any order of selection which would otherwise be followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

(3) In the case of any State which does not have a plan which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

(4) Payments under this subsection may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

(5) Money paid from the Trust Funds under this subsection to pay the costs of providing services to individuals who are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid out from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

(A) the total cost of the services provided under this subsection, and

(B) subject to the provisions of the preceding sentence, the amount of such cost which should be charged to each of such Trust Funds.

(6) For the purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection.

Disability Insurance Benefit Payments

Disability Insurance Benefits

Sec. 223. (a) (1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c) (1)),

[(B) has not attained the age of sixty-five,]

(B) in the case of any individual other than an individual whose disability is blindness (as defined in section 216(i) (1) (B)), has not attained the age of 65,

(C) has filed application for disability insurance benefits, and

(D) is under a disability (as defined in subsection (d)) shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c) (2)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216(i)) which ceased, within the sixty-month period preceding the first month in which he is under such disability, and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, **the month in which he attains age 65,]** *in the case of any individual other than an individual whose disability is blindness (as defined in section 216(i) (1) (B)), the month in which he attains age 65 or the third month following the month in which his disability ceases. [No payment under this paragraph may be made to an individual who would not meet the definition of disability in subsection (d) except for paragraph (1) (B) thereof for any month in which he engages in substantial gainful activity, and no payment may be made for such month under subsection (b), (c), or (d) of section 202 to any person on the basis of the wages and self-employment income of such individual.] In the case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died.¹*

(2) Except as provided in section 202(q), such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained age 62 **[(if a woman) or age 65 (if a man)],²** *and, in the case of any individual whose disability is blindness (as defined in section 216(i) (1) (B)), as though he were a fully insured individual, in—*

¹ Applies in case of deaths occurring after Dec. 31, 1969. Applications with respect to deaths occurring after Dec. 31, 1969, but before date of enactment which are filed in, or within 3 months after, the month of enactment shall be deemed filed in the month in which such death occurred.

² Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

(A) the first month of his waiting period, or
 (B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,
 and as though he had become entitled to old-age insurance benefits in the month in which [he filed his application for disability insurance benefits and was] *the application for disability insurance benefits was filed and he was* entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit. For the purposes of the preceding sentence, [in the case of a woman] *in the case of an individual*¹ who attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b)(3) shall not include the year in which [she] *he*² attained age 62, or any year thereafter.

Filing of Application

(b) An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If, upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month. An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month [if he files such application] *if such application is filed* before the end of the 12th month immediately succeeding such month.

Definitions of Insured Status and Waiting Period

(c) For purposes of this section—

(1) An individual (*other than an individual whose disability is blindness, as defined in section 216(i)(1)(B)*), shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 [(if a woman) or age 65 (if a man)]³ and filed application for benefits under section 202(a) on the first day of such month, and

(B) (i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or

¹ Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

² Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

³ Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

In the case of a man who attains or will attain age 62 in 1973, the figure "65" shall be deemed to read "64".

In the case of a man who attains or will attain age 62 in 1974, the figure "65" shall be deemed to read "63".

(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with the quarter in which such month occurred and beginning after he attained age 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage. For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.

An individual whose disability is blindness (as defined in section 216(i)(1)(B)) shall be insured for disability insurance benefits in any month if he had not less than six quarters of coverage before the quarter in which such month occurs.

(2) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of ~~["six"]~~ four consecutive calendar months—

(A) throughout which the individual ~~["who files such application"]~~ with respect to whom such application is filed¹ has been under a disability, and

(B) (i) which begins not earlier than with the first day of the ~~["eighteenth"]~~ *sixteenth* month before the month in which such application is filed if such individual is insured for disability insurance benefits in such ~~["eighteenth"]~~ *sixteenth* month, or (ii) if he is not so insured in such month, which begins not earlier than the first day of the first month after ~~["eighteenth"]~~ *sixteenth* month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

Definition of Disability

(d) (1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

~~["(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage~~

¹ Applies in case of deaths occurring after Dec. 31, 1969. Applications with respect to deaths occurring after Dec. 31, 1969, but before date of enactment which are filed in, or within 3 months after, the month of enactment shall be deemed filed in the month in which such death occurred.

in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.】

(B) *blindness (as defined in section 216(i)(1)(B))*

(2) For purposes of paragraph (1)(A)—

(A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 202 (e) or (f); and except a brother for purposes of section 202(x)) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity 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. For purposes of the preceding sentence (with respect to any individual), “work which exists in the national economy” means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) A widow, surviving divorced wife, or widower shall not be determined to be under a disability (for purposes of section 202 (e) or (f) unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity.

(3) For purposes of this subsection, a “physical or mental impairment” is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual’s ability to engage in substantial gainful activity. Notwithstanding the provisions of paragraph (2), an individual (*other than an individual whose disability is blindness, as defined in section 216(i)(1)(B)*) whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled.

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

Reduction of Benefits Based on Disability on Account of Receipt of Workmen’s Compensation

Sec. 224. (a) If for any month prior to the month in which an individual attains the age of 62—

- (1) such individual is entitled to benefits under section 223, and
- (2) such individual is entitled for such month, under a workmen’s compensation law or plan of the United States or a State

to periodic benefits for a total or partial disability (whether or not permanent), and the Secretary has, in a prior month, received notice of such entitlement for such month, the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(3) such total of benefits under sections 223 and 202 for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under the workmen's compensation law or plan,

exceeds the higher of—

(5) 80 per centum of his "average current earnings", or

(6) the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section.

In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month (in a continuous period of months) reduce such total below the sum of—

(7) the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

For purposes of clause (5), an individual's average current earnings means the **[larger]** *largest*¹ of (A) the average monthly wage used for purposes of computing his benefits under section 223, **[or]** (B) one-sixtieth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a) and 211(b)(1)) for the five consecutive calendar years after 1950 for which such wages and self-employment income were highest, or (C) *one-twelfth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a) and 211(b)(1)) for the calendar year in which he had the highest such wages and income during the period consisting of the calendar year in which he became disabled (as defined in section 223(d)) and the five years preceding that year.*² In any case where an individual's wages and self-employment income reported to the Secretary for a calendar year reach the limitations specified in sections 209(a) and 211(b)(1), the Secretary under regulations shall estimate the total of such wages and self-employment income for purposes of **[clause (B)]** *clauses (B) and (C)*² of the preceding sentence on the basis of such information

¹ Applies to benefits for months after December 1972.

² Applies to benefits for months after December 1972.

as may be available to him indicating the extent (if any) by which such wages and self-employment income exceed such limitations.

(b) If any periodic benefit under a workmen's compensation law or plan is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate as nearly as practicable the reduction prescribed by subsection (a).

(c) Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 203, but before deductions under such section and under section 222(b).

(d) The reduction of benefits required by this section shall not be made if the workmen's compensation law or plan under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title on the basis of the wages and self-employment income of an individual entitled to benefits under section 223.

(e) If it appears to the Secretary that an individual may be eligible for periodic benefits under a workmen's compensation law or plan which would give rise to reduction under this section, he may require, as a condition of certification for payment of any benefits under section 223 to any individual for any month and of any benefits under section 202 of such month based on such individual's wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Secretary may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205(i).

(f)(1) In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 223 and any benefits under section 202 based on his wages and self-employment income was first required (in a continuous period of months), and in each third year thereafter, the Secretary shall redetermine the amount of such benefits which are still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this title on the basis of such individual's wages and self-employment income. Such redetermined benefit shall be determined as of, and shall become effective with, the January following the year in which such redetermination was made.

(2) In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of his average current earnings as initially determined under subsection (a) and the ratio of (i) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which such redetermination is made, to (ii) the average of the taxable wages of such persons reported to the Secretary

for the first calendar quarter of the taxable year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability). Any amount determined under the preceding sentence which is not a multiple of \$1 shall be reduced to the next lower multiple of \$1.

(g) Whenever a reduction in the total of benefits for any month based on an individual's wages and self-employment income is made under this section, each benefit, except the disability insurance benefit, shall first be proportionately decreased, and any excess of such reduction over the sum of all such benefits other than the disability insurance benefit shall then be applied to such disability insurance benefit.

Suspension of Benefits Based on Disability

Sec. 225. If the Secretary, on the basis of information obtained by or submitted to him, believes that an individual entitled to benefits under section 223, or that a child who has attained the age of eighteen and is entitled to benefits under section 202(d), or that a widow or surviving divorced wife who has not attained age 60 and is entitled to benefits under section 202(e), or that a widower who has not attained age [62] 60¹ and is entitled to benefits under section 202(f), may have ceased to be under a disability, the Secretary may suspend the payment of benefits under such section 202(d), 202(e), 202(f), or 223, until it is determined (as provided in section 221) whether or not such individual's disability has ceased or until the Secretary believes that such disability has not ceased. In the case of any individual whose disability is subject to determination under an agreement with a State under section 221(b), the Secretary shall promptly notify the appropriate State of his action under this section and shall request a prompt determination of whether such individual's disability has ceased. For purposes of this section, the term "disability" has the meaning assigned to such term in section 223(d). Whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 202, on the basis of the wages and self-employment income of such individual, shall be suspended for such month. The first sentence of this section shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).

Entitlement to Hospital Insurance Benefits

Sec. 226.

(a) (1) Every individual who—
 [(1)] (A) has attained age 65, and
 [(2)] (B) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,
 shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in

¹ Applies to benefits payable under section 202 for months after December 1972, except that in the case an individual not entitled to a benefit for December 1972, benefits will be payable only on the basis of an application filed in or after the month of enactment.

subparagraph [(2)](B), beginning with the first month after June 1966 for which he meets the conditions specified in subparagraphs [(1)](A) and [(2)](B).

(b) *Every individual who—*

(1) *has not attained age 65, and*

(2) (A) *is entitled to, and has for 24 consecutive calendar months been entitled to, (i) disability insurance benefits under section 223, or (ii) child's insurance benefits under section 202(d) or sister's and brother's benefits under section 202(x) by reason of a disability (as defined in section 223(d)), or (iii) widow's insurance benefits under section 202(e), or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)) or (B) is, and has been for not less than 24 consecutive months, a disabled qualified railroad retirement beneficiary, within the meaning of section 22 of the Railroad Retirement Act of 1937,*

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth consecutive month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65.

(c) *For purposes of subsection (a)—*

(1) *entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, post-hospital home health services, and eligible drugs¹ (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or post-hospital home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to paragraph (2) of subsection (a), at a time when he was so entitled; and*

(2) *an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.*

¹ Applies to eligible drugs furnished on and after July 1, 1973.

(d) For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 or section 22 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 21 or section 22 of the Railroad Retirement Act of 1937.

(e) (1) For purposes of determining entitlement to hospital insurance benefits under subsection (a) (2) in the case of widows and widowers described in subparagraph (B) (iii) thereof—

(A) the term "age 60" in sections 202(e) (1) (B) (ii) and 202(e) (5), and the term "age 62" in sections 202(f) (1) (B) (ii) and 202(f) (6) shall be deemed to read "age 65"; and

(B) the phrase "before she attained age 60" in the matter following subparagraph (F) of section 202(e) (1) shall be deemed to read "based on a disability".

(2) For purposes of determining entitlement to hospital insurance benefits under subsection (a) (2) in the case of an individual under age 65 who is entitled to benefits under section 202 and who was entitled to widow's insurance benefits or widower's insurance benefits based on disability for the month before the first month in which such individual was so entitled to old-age insurance benefits (but ceased to be entitled to such widow's or widower's insurance benefits upon becoming entitled to such old-age insurance benefits), such individual shall be deemed to have continued to be entitled to such widow's insurance benefits or widower's insurance benefits for and after such first month.

(3) For purposes of determining entitlement to hospital insurance benefits under subsection (a) (2) any disabled widow age 50 or older who is entitled to mother's insurance benefits (and who would have been entitled to widow's insurance benefits by reason of disability if she had filed for such widow's benefits) shall, upon application therefor, be deemed to have filed for such widow's benefits at the time she filed for mother's insurance benefits and shall, upon furnishing proof of such disability prior to July 1, 1974, under such procedures as the Secretary may prescribe, be deemed to have been entitled to such widow's benefits as of the time she would have been entitled to such widow's benefits if she had filed a timely application therefor.

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

Transitional Insured Status

Sec. 227. (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in [so much of paragraph (1) of section 214(a) as follows clause (C)] paragraph (1) of section 214(a)¹ shall, instead, be 3 quarters of coverage for purposes

¹ Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

of determining entitlement of such individual to benefits under section 202(a), and of his wife to benefits under section 202(b), but, in the case of such wife, only if she attains the age of 72 before 1969 and only with respect to wife's insurance benefits under section 202(b) for and after the month in which she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of his old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be \$58.00¹ and the amount of the wife's insurance benefit of his wife shall, notwithstanding the provisions of section 202(b), be \$29.00.¹

(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose widow attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in [so much of paragraph (1) thereof as follows clause (C)] *paragraph (1) thereof*² shall, for purposes of determining her entitlement to widow's insurance benefits under section 202(e), instead be—

- (1) 3 quarters of coverage if such widow attains the age of 72 in or before 1966.
- (2) 4 quarters of coverage if such widow attains the age of 72 in 1967, or
- (3) 5 quarters of coverage if such widow attains the age of 72 in 1968.

The amount of her widow's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) (and section 202(m)), be \$58.00.¹

(c) In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose widow attains the age of 72 before 1969, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such widow to widow's insurance benefits under section 202(e).

Benefits at Age 72 for Certain Uninsured Individuals

Eligibility

Sec. 228. (a) Every individual who—

- (1) has attained the age of 72,
- (2) (A) attained such age before 1968, or (B) has not less than 3 quarters of coverage, whenever acquired, for each calendar year elapsing after 1966 and before the year in which he attained such age,
- (3) is a resident of the United States (as defined in subsection (e)), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as defined in section 210(i)) continuously during

¹ Effective January 1, 1975, "the larger of \$58.00 or the amount most recently established in lieu thereof under section 215(i)" will replace "\$58.00" and "the larger of \$29.00 or the amount most recently established in lieu thereof under section 215(i)" will replace "\$29.00" wherever they appear in sections 227 and 228. (P.L. 92-336 sec. 202(a)(4)).

² Applies only in the case of a man who attains (or would attain) age 62 after December 1974.

the 5 years immediately preceding the month in which he files application under this section, and

(4) has filed application for benefits under this section, shall (subject to the limitations in this section) be entitled to a benefit under this section for each month beginning with the first month after September 1966 in which he becomes so entitled to such benefits and ending with the month preceding the month in which he dies. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), and (3) shall be accepted as an application for purposes of this section,

Benefit Amount

(b) (1) Except as provided in paragraph (2), the benefit amount to which an individual is entitled under this section for any month shall be \$58.00.

(2) If both husband and wife are entitled (or upon application would be entitled) to benefits under this section for any month, the amount of the husband's benefit for such month shall be \$58.00 and the amount of the wife's benefit for such month shall be \$29.00.

Reduction for Governmental Pension System Benefits

(c) (1) The benefit amount of any individual under this section for any month shall be reduced (but not below zero) by the amount of any periodic benefit under a governmental pension system for which he is eligible for such month.

(2) In the case of a husband and wife only one of whom is entitled to benefits under this section for any month, the benefit amount, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the spouse who is not entitled to benefits under this section is eligible for such month, over (B) \$29.00.

(3) In the case of a husband and wife both of whom are entitled to benefits under this section for any month—

(A) the benefit amount of the wife, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the husband is eligible for such month, over (ii) \$58.00; and

(B) the benefit amount of the husband, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the wife is eligible for such month, over (ii) \$29.00.

(4) For purposes of this subsection, in determining whether an individual is eligible for periodic benefits under a governmental pension system—

(A) such individual shall be deemed to have filed application for such benefits,

(B) to the extent that entitlement depends on an application by such individual's spouse, such spouse shall be deemed to have filed application, and

(C) to the extent that entitlement depends on such individual or his spouse having retired, such individual and his spouse shall be deemed to have retired before the month for which the determination of eligibility is being made.

(5) For purposes of this subsection, if any periodic benefit is payable on any basis other than a calendar month, the Secretary shall allocate the amount of such benefit to the appropriate calendar months.

(6) If, under the foregoing provisions of this section, the amount payable for any month would be less than \$1, such amount shall be reduced to zero. In the case of a husband and wife both of whom are entitled to benefits under this section for the month, the preceding sentence shall be applied with respect to the aggregate amount so payable for such month.

(7) If any benefit amount computed under the foregoing provisions of this section is not a multiple of \$0.10, it shall be raised to the next higher multiple of \$0.10.

(8) Under regulations prescribed by the Secretary, benefit payments under this section to an individual (or aggregate benefit payments under this section in the case of a husband and wife) of less than \$5 may be accumulated until they equal or exceed \$5.

Suspension for Months in Which Cash Payments Are Made Under Public Assistance

(d) The benefit to which any individual is entitled under this section for any month shall not be paid for such month if—

(1) such individual receives aid or assistance in the form of money payments in such month under a State plan approved under title I, X, XIV, XV or XVI or part A of title IV or *supplemental security income benefits under title XVI (as in effect after December 31, 1973)*, or

(2) such individual's husband or wife receives such aid or assistance in such month, and under the State plan the needs of such individual were taken into account in determining eligibility for (or amount of) such aid or assistance, unless the State agency administering or supervising the administration of such plan notifies the Secretary, at such time and in such manner as may be prescribed in accordance with regulations of the Secretary, that such payments to such individual (or such individual's husband or wife) under such plan are being terminated with the payment or payments made in such month.

Suspension Where Individual Is Residing Outside the United States

(e) The benefit to which any individual is entitled under this section for any month shall not be paid if, during such month, such individual is not a resident of the United States. For purposes of this

subsection, the term "United States" means the 50 States and the District of Columbia.

Treatment as Monthly Insurance Benefits

(f) For purposes of subsections (t) and (u) of section 202, and of section 1840 a monthly benefit under this section shall be treated as a monthly insurance benefit payable under section 202.

Annual Reimbursement of Federal Old-Age and Survivors Insurance Trust Fund

(g) There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1969, and for each fiscal year thereafter, such sums as the Secretary of Health, Education, and Welfare deems necessary on account of—

(1) payments made under this section during the second preceding fiscal year and all fiscal years prior thereto to individuals who, as of the beginning of the calendar year in which falls the month for which payment was made, had less than 3 quarters of coverage,

(2) the additional administrative expenses resulting from the payments described in paragraph (1), and

(3) any loss in interest to such Trust Fund resulting from such payments and expenses,

in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if such payments had not been made.

Definitions

(h) For purposes of this section—

(1) The term "quarter of coverage" includes a quarter of coverage as defined in section 5(1) of the Railroad Retirement Act of 1937.

(2) The term "governmental pension system" means the insurance system established by this title or any other system or fund established by the United States, a State, any political subdivision of a State, or any wholly owned instrumentality of any one or more of the foregoing which provides for payment of (A) pensions, (B) retirement or retired pay, or (C) annuities or similar amounts payable on account of personal services performed by any individual (not including any payment under any workmen's compensation law or any payment by the Veterans' Administration as compensation for service-connected disability or death).

(3) The term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(4) The determination of whether an individual is a husband or wife for any month shall be made under subsection (h) of section 216 without regard to subsections (b) and (f) of section 216.

Benefits in Case of Members of the Uniformed Services

Sec. 229. (a) For purposes of determining entitlement to and the amount of any monthly benefit for any month [after December 1967] *after December 1972*,¹ or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual shall be deemed to have been paid, in each calendar quarter occurring [after 1967] *after 1956*¹ in which he was paid wages for service as a member of a uniformed service (as defined in section 210(m)) which was included in the term "employment" as defined in section 210(a) as a result of the provisions of section 210(1), wages (in addition to the wages actually paid to him for such service) [of—

[(1) \$100 if the wages actually paid to him in such quarter for such services were \$100 or less,

[(2) \$200 if the wages actually paid to him in such quarter for such services were more than \$100 but not more than \$200, or

[(3) \$300 in any other case.]

*of \$300.*²

(b) There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund annually, as benefits under this title and part A of title XVIII are paid after December 1967, such sums as the Secretary determines to be necessary to meet (1) the additional costs, resulting from subsection (a), of such benefits (including lump-sum death payments), (2) the additional administrative expenses resulting therefrom, and (3) any loss in interest to such trust funds resulting from the payment of such amounts. Such additional costs shall be determined after any increases in such benefits arising from the application of section 217 have been made.

Adjustment of the Contribution and Benefit Base

Sec. 230. (a) Whenever the Secretary pursuant to section 215(i) increases benefits effective with the first month of the calendar year following a cost-of-living computation quarter, he shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs (along with the publication of such benefit increase as required by section 215(i)(2)(D)) the contribution and benefit base determined under subsection (b) which shall be effective (unless such increase in benefits is prevented from becoming effective by section 215(i)(2)(E)) with respect to remuneration paid after the calendar year in which such quarter occurs and taxable years beginning after such year.

(b) The amount of such contribution and benefit base shall be the amount of the contribution and benefit base in effect in the year in which the determination is made or, if larger, the product of—

(1) the contribution and benefit base which was in effect with respect to remuneration paid in (and taxable years beginning in)

¹ Applies to benefits for months after December 1972 and to lump-sum death payments for deaths occurring after December 1972, subject to exception in section 126(b) of the amendments.

² See footnote 1.

the calendar year in which the determination under subsection (a) with respect to such particular calendar year was made, and

(2) the ratio of (A) the average of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of the calendar year in which the determination under subsection (a) with respect to such particular calendar year was made to the latest [or] of (B) the average of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of 1973 or the first calendar quarter of the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination resulting in such an increase was made under subsection (a),

with such product, if not a multiple of \$300, being rounded to the next higher multiple of \$300 where such product is a multiple of \$150 but not of \$300 and to the nearest multiple of \$300 in any other case.

(c) For purposes of this section, and for purposes of determining wages and self-employment income under sections 209, 211, 213, and 215 of this Act and sections 1402, 3121, 3122, 3125, 6413, and 6654 of the Internal Revenue Code of 1954, the "contribution and benefit base" with respect to remuneration paid in (and taxable years beginning in) any calendar year after 1973 and prior to the calendar year with the first month of which the first increase in benefits pursuant to section 215(i) of this Act becomes effective shall be \$12,000 or (if applicable) such other amount as may be specified in a law enacted subsequent to the law which added this section.

Benefits in Case of Certain Individuals Interned During World War II

Sec. 231. (a) *For the purposes of this section the term "internee" means an individual who was interned during any period of time from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry.*

(b) (1) *For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in the case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual shall be deemed to have been paid during any period after he attained age 18 and for which he was an internee, wages (in addition to any wages actually paid to him) at a weekly rate of basic pay during such period as follows—*

(A) *in the case such individual was not employed prior to the beginning of such period, 40 multiplied by the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, United States Code, for each full week during such period; and*

(B) *in the case such individual who was employed prior to the beginning of such period, 40 multiplied by the greater of (i) the highest hourly rate received during any such employment, or (ii) the minimum hourly rate or rates in effect at any such time under*

section 206(a)(1) of title 29, United States Code, for each full week during such period.

(2) This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump-sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon internment during any period from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry, is determined by any agency or wholly owned instrumentality of the United States to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by \$0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

(3) Upon application for benefits, a recalculation of benefits (by reason of this section), or a lump-sum death payment on the basis of the wages and self-employment income of any individual who was an internee, the Secretary of Health, Education, and Welfare shall accept the certification of the Secretary of Defense or his designee concerning any period of time for which an internee is to receive credit under paragraph (1) and shall make a decision without regard to clause (B) of paragraph (2) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the period for which such individual was an internee, a benefit described in clause (B) of paragraph (2) has been determined by such agency or instrumentality to be payable by it. If the Secretary of Health, Education, and Welfare has not been so notified, he shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (2) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by this section.

(4) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on any period for which any individual was an internee shall, at the request of the Secretary of Health, Education, and Welfare, certify to him, with respect to any individual who was an internee such information as the Secretary deems necessary to carry out his functions under paragraph (3) of this subsection.

(c) *In the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom this section applies, to monthly benefits under title II of such Act for the month in which this Act is enacted, this section shall apply (1) only if a written request for a recalculation of such benefits (by reason of this section) under the provisions of section 215 (b) and (d) of such Act, as in effect at the time such request is filed, is filed by such individual, or any other individual, entitled to benefits under such title II on the basis of such wages and self-employment income, and (2) only with respect to such benefits for months beginning with whichever of the following is later: January 1973 or the twelfth month before the month in which such request was filed. Recalculations of benefits as required to carry out the provisions of this section shall be made notwithstanding the provisions of section 215(f) (1) of the Social Security Act, and no such recalculation shall be regarded as a recomputation for purposes of section 215(f) of such Act.*

(d) *There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund for the fiscal year ending June 30, 1978, such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position in which they would have been if the preceding provisions of this section had not been enacted.*

* * * * *

**TITLE IV—GRANTS TO STATES FOR AID AND SERVICES
TO NEEDY FAMILIES WITH CHILDREN AND FOR
CHILD-WELFARE SERVICES**

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**[PART A—AID TO FAMILIES WITH DEPENDENT
CHILDREN**

[Appropriation

[Section 401. For the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditions in such State, to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under

this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid and services to needy families with children.

State Plans for Aid and Services to Needy Families with Children

Section 402. (a) A State plan for aid and services to needy families with children must

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

[(2) provide for financial participation by the State;

[(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

[(4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with dependent children is denied or is not acted upon with reasonable promptness;

[(5) provide (A) such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community services aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; and

[(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

[(7) except as may be otherwise provided in clause (8), provide that the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid, as well as any expenses reasonably attributable to the earning of any such income;

[(8) provide that, in making the determination under clause (7), the State agency—

[(A) shall with respect to any month disregard—

[(i) all of the earned income of each dependent child receiving aid to families with dependent children who is (as

determined by the State in accordance with standards prescribed by the Secretary) a full-time student or part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment, and

[(ii) in the case of earned income of a dependent child not included under clause (i), a relative receiving such aid, and any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$30 of the total of such earned income for such month plus one-third of the remainder of such income for such month (except that the provisions of this clause (ii) shall not apply to earned income derived from participation on a project maintained under the programs established by section 432(b) (2) and (3); and

[(B) (i) may, subject to the limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child, and (ii) may, before disregarding the amounts referred to in subparagraph (A) and clause (i) of this subparagraph, disregard not more than \$5 per month of any income; except that, with respect to any month, the State agency shall not disregard any earned income (other than income referred to in subparagraph (B)) of—

[(C) any one of the persons specified in clause (ii) of subparagraph (A) if such person—

[(i) terminated his employment or reduced his earned income without good cause within such period (of not less than 30 days) preceding such month as may be prescribed by the Secretary; or

[(ii) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State or local agency administering the State plan, after notification by him, to be a bona fide offer of employment; or

[(D) any of such persons specified in clause (ii) of subparagraph (A) if with respect to such month the income of the persons so specified (within the meaning of clause (7)) was in excess of their need as determined by the State agency pursuant to clause (7) (without regard to clause (8)), unless, for any one of the four months preceding such month, the needs of such person were met by the furnishing of aid under the plan;

[(9) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to families with dependent children;

[(10) provide, effective July 1, 1951, that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent

children shall be furnished with reasonable promptness to all eligible individuals;

[(11) effective July 1, 1952, provide for prompt notice to appropriate law-enforcement officials of the furnishing of aid to families with dependent children in respect of a child who has been deserted or abandoned by a parent;

[(12) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act;

[(13) provide a description of the services which the State agency makes available to maintain and strengthen family life for children, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

[(14) provide for the development and application of a program for such family services as defined in section 406(d) and child welfare services, as defined in section 425, for each child and relative who receives aid to families with dependent children and each appropriate individual (living in the same home as a relative and child receiving such aid whose needs are taken into account in making the determination under clause (7)), as may be necessary in the light of the particular home conditions and other needs of such child, relative, and individuals, in order to assist such child, relative, and individuals to attain or retain capability for self-support and care and in order to maintain and strengthen family life and to foster child development;

[(15) provide—

[(A) for the development of a program, for each appropriate relative and dependent child receiving aid under the plan, and each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under clause (7), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases family planning services are offered to them, but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and

[(B) to the extent that services provided under this clause or clause (14) are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishing of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services;

[(16) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have;

[(17) provide—

[(A) for the development and implementation of a program under which the State agency will undertake—

[(i) in the case of a child born out of wedlock who is receiving aid to families with dependent children to establish the paternity of such child and secure support for him, and

[(ii) in the case of any child receiving such aid who has been deserted or abandoned by his parent, to secure support for such child from such parent (or from any other person legally liable for such support), utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support, and

[(B) for the establishment of a single organizational unit in the State agency or local agency administering the State plan in each political subdivision which will be responsible for the administration of the program referred to in clause (A);

[(18) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials (A) to assist the State agency in administering the program referred to in clause (17) (A), including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the State agency or local agency administering the State plan;

[(19) provide—

[(A) that every individual, as a condition of eligibility for and under this part, shall register for manpower services, training, and employment as provided by regulations of the Secretary of Labor, unless such individual is—

[(i) a child who is under age 16 or attending school full time;

[(ii) a person who is ill, incapacitated, or of advanced age;

[(iii) a person so remote from a work incentive project that his effective participation is precluded;

[(iv) a person whose presence in the home is required because of illness or incapacity of another member of the household;

[(v) a mother or other relative of a child under the age of six who is caring for the child; or

[(vi) the mother or other female caretaker of a child, if the father or another adult male relative is in the home and not excluded by clause (i), (ii), (iii), or (iv) of this subparagraph (unless he has failed to register as required by this subparagraph, or has been found by the Secretary of Labor under section 433(g) to have refused without good cause to participate under a work incentive program or accept employment as described in subparagraph (F) of this paragraph);

and that any individual referred to in clause (v) shall be advised of her option to register, if she so desires, pursuant to this paragraph, and shall be informed of the child care services (if any) which will be available to her in the event she should decide so to register;

[(B) that aid under the plan will not be denied by reason of such registration or the individual's certification to the Secretary of Labor under subparagraph (G) of this paragraph, or by reason of an individual's participation on a project under the program established by section 432(b) (2) or (3);

[(C) for arrangements to assure that there will be made a non-Federal contribution to the work incentive programs established by part C by appropriate agencies of the State or private organizations of 10 per centum of the cost of such programs, as specified in section 435(b);

[(D) that (i) training incentives authorized under section 434, and income derived from a special work project under the program established by section 432(b) (3) shall be disregarded in determining the needs of an individual under section 402(a) (7), and (ii) in determining such individual's needs the additional expenses attributable to his participation in a program established by section 432(b) (2) or (3) shall be taken into account;

[(E) [Repealed].

[(F) that if and for so long as any child, relative, or individual (certified to the Secretary of Labor pursuant to subparagraph (G)) has been found by the Secretary of Labor under section 433(g) to have refused without good cause to participate under a work incentive program established by part C with respect to which the Secretary of Labor has determined his participation is consistent with the purposes of such part C, or to have refused without good cause to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined, after notification by him, to be a bona fide offer of employment—

[(i) if the relative makes such refusal, such relative's needs shall not be taken into account in making the determination under clause (7), and aid for any dependent child in the family in the form of payments of the type described in section 406(b) (2) (which in such a case shall be without regard to clauses (A) through (E) thereof) or section 408 will be made;

[(ii) aid with respect to a dependent child will be denied if a child who is the only child receiving aid in the family makes such refusal;

[(iii) if there is more than one child receiving aid in the family, aid for any such child will be denied (and his needs will not be taken into account in making the determination under clause (7)) if that child makes such refusal; and

[(iv) if such individual makes such refusal, such individual's needs shall not be taken into account in making the determination under clause (7);

except that the State agency shall for a period of sixty days, make payments of the type described in section 406(b) (2) (without regard to clauses (A) through (E) thereof) on behalf of the relative specified in clause (i), or continue aid in the case of a child

specified in clause (ii) or (iii), or take the individual's needs into account in the case of an individual specified in clause (iv), but only if during such period such child, relative, or individual accepts counseling or other services (which the State agency shall make available to such child, relative, or individual) aimed at persuading such relative, child, or individual, as the case may be, to participate in such program in accordance with the determination of the Secretary of Labor; and

[(G) that the State agency will have in effect a special program which (i) will be administered by a separate administrative unit and the employees of which will, to the maximum extent feasible, perform services only in connection with the administration of such program, (ii) will provide (through arrangements with others or otherwise) for individuals who have been registered pursuant to subparagraph (A), in accordance with the order of priority listed in section 433(a), such health, vocational rehabilitation, counseling, child care, and other social and supportive services as are necessary to enable such individuals to accept employment or receive manpower training provided under part C, and will, when arrangements have been made to provide necessary supportive services, including child care, certify to the Secretary of Labor those individuals who are ready for employment or training under part C, (iii) will participate in the development of operational and employability plans under section 433(b); and (iv) provides for purposes of clause (ii), that, when more than one kind of child care is available, the mother may choose the type, but she may not refuse to accept child care services if they are available;

[(20) effective July 1, 1969, provide for aid to families with dependent children in the form of foster care in accordance with section 408;

[(21) provide that the State agency will report to the Secretary, at such times (not less often than once each calendar quarter) and in such manner as the Secretary may prescribe—

[(A) the name, and social security account number, if known, of each parent of a dependent child or children with respect to whom aid is being provided under the State plan—

[(i) against whom an order for the support and maintenance of such child or children has been issued by a court of competent jurisdiction but who is not making payments in compliance or partial compliance with such order, or against whom a petition for such an order has been filed in a court having jurisdiction to receive such petition, and

[(ii) whom it has been unable to locate after requesting and utilizing information included in the files of the Department of Health, Education, and Welfare maintained pursuant to section 205,

[(B) the last known address of such parent and any information it has with respect to the date on which such parent could last be located at such address, and

[(C) such other information as the Secretary may specify to assist in carrying out the provisions of section 410;

[(22) provide that the State agency will, in accordance with standards prescribed by the Secretary, cooperate with the State agency administering or supervising the administration of the plan of another State under this part—

[(A) in locating a parent residing in such State (whether or not permanently) against whom a petition has been filed in a court of competent jurisdiction of such other State for the support and maintenance of a child or children of such parent with respect to whom aid is being provided under the plan of such other State, and in securing compliance or good faith partial compliance by a parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of a child or children of such parent with respect to whom aid is being provided under the plan of such other State; and

[(23) provide that by July 1, 1969, the amounts used by the State to determine the needs of individuals will have been adjusted to reflect fully changes in living costs since such amounts were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted.

[(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for (aid to families with dependent children) a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

[(c) The Secretary shall, on the basis of his review of the reports received from the States under clause (15) of subsection (a), compile such data as he believes necessary and from time to time publish his findings as to the effectiveness of the programs developed and administered by the States under such clause. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the programs developed and administered by each State under such clause (15).

[(Payment to States

[Sec. 403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall (subject to subsection (d)) pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

[(A) five-sixths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$18 multiplied by the total number of recipients of aid to families with dependent children for such month (which total number, for purposes of this subsection, means (i) the number of individuals with respect to whom such aid in the form of money payments is paid for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to families with dependent children in the form of medical or any other type of remedial care, plus (iii) the number of individuals, not counted under clause (i) or (ii), with respect to whom payments described in section 406(b)(2) are made in such month and included as expenditures for purposes of this paragraph or paragraph (2)); plus

[(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (i) the product of \$32 multiplied by the total number of recipients of aid to families with dependent children (other than such aid in the form of foster care) for such month, plus (ii) the product of \$100 multiplied by the total number of recipients of aid to families with dependent children in the form of foster care for such month; and

[(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of Title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof) not counting so much of any expenditure with respect to any month as exceeds \$18 multiplied by the total number of recipients of such aid for such month; and

[(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) any of the services described in clauses (14) and (15) of section 402(a) which are provided to any child or relative who is receiving aid under the plan, or to any other individual (living in the same home as such relative and child) whose needs are taken into account in making the determination under clause (7) of such section,

[(ii) any of the services described in clauses (14) and (15) of 402(a) which are provided to any child or relative who is applying for aid to families with dependent children or who, within such period or periods as the

Secretary may prescribe, has been or is likely to become an applicant for or recipient of such aid,

[(iii) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,

[(B) one-half of the remainder of such expenditures.

[The services referred to in subparagraph (A) shall include only—

[(C) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this part shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (D), if provided by such staff, and

[(D) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contact with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (C) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved; and except that, to the extent specified by the Secretary, child-welfare services, family planning services, and family services may be provided from sources other than those referred to in subparagraphs (C) and (D). The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraph (B) applies shall be determined in accordance with such methods and procedures as may be permitted by the Secretary.

[[(4) Repealed]

[(5) in the case of any State an amount equal to the sum of—

[(A) 50 per centum of the total amount expended under the State plan during such quarter as emergency assistance to needy families with children in the form of payments or care specified in paragraph (1) of section 406(e), and

[(B) 75 per centum of the total amount expended under the State plan during such quarter as emergency assistance to needy families with children in the form of services specified in paragraph (1) of section 406(e).

[The number of individuals with respect to whom payments described in section 406(b)(2) are made for any month, who may be included as recipients of aid to families with dependent children for purposes of paragraph (1) or (2), may not exceed 10 per centum of the number of other recipients of aid to families with dependent children for such month. In computing such 10 percent, there shall not be taken into account individuals with respect to whom such payments are made for any month in accordance with section 402(a)(19)(F).

[(b) The method of computing and paying such amounts shall be as follows:

[(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarters, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of dependent children in the State, and (C) such other investigation as the Secretary may find necessary.

[(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to aid to families with dependent children furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter.

[(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State,

at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

[(c) Notwithstanding any other provision of this Act, the Federal share of assistance payments under this part shall be reduced with respect to any State for any fiscal year after June 30, 1973, by one percentage point for each percentage point by which the number of individuals certified, under the program of such State established pursuant to section 402(a)(19)(G), to the local employment office of the State as being ready for employment or training under part C, is less than 15 per centum of the average number of individuals in such State who, during such year, are required to be registered pursuant to section 402(a)(19)(A).

[(d)(1) Notwithstanding subparagraph (A) of subsection (a)(3) the rate specified in such subparagraph shall be 90 per centum (rather than 75 per centum) with respect to social and supportive services provided pursuant to section 402(a)(19)(G).

[(2) Of the sums authorized by section 401 to be appropriated for the fiscal year ending June 30, 1973, not more than \$750,000,000 shall be appropriated to the Secretary for payments with respect to services to which paragraph (1) applies.

Operation of State Plans

[Sec. 404. (a) In the case of any State plan for aid and services to needy families with children which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

[(1) that the plan has been so changed as to impose any residence requirement prohibited by section 402(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or (2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 402(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[(b) No payment to which a State is otherwise entitled under this title for any period before September 1, 1962, shall be withheld by reason of any action taken pursuant to a State statute which requires that aid be denied under the State plan approved under this part with respect to a child because of the conditions in the home in which the child resides; nor shall any such payment be withheld for any period beginning on or after such date by reason of any action taken pursuant to such a statute if provision is otherwise made pursuant to a State statute for adequate care and assistance with respect to such child.

[Use of Payments for Benefit of Child

[Sec. 405. Whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency may provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and may provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as provided under section 406(b)(2), or in seeking appointment of a guardian or legal representative as provided in section 1111, or in the imposition of criminal or civil penalties authorized under State law if it is determined by a court of competent jurisdiction that such relative is not using or has not used for the benefit of the child any such payments made for that purpose; and the provision of such services or advice by the State agency (or the taking of the action specified in such advice) shall not serve as a basis for withholding funds from such State under section 404 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children.

[Definitions

[Sec. 406. When used in this part—

[a) The term “dependent child” means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen or (B) under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment.

[b) The term “aid to families with dependent children” means money payments with respect to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, a dependent child or dependent children, and includes (1) money payments or medical care or any type of remedial care recognized under State law to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child’s parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 407), and (2) payments with respect to any dependent child (including pay-

ments to meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 402(a)(1) which do not meet the preceding requirements of this subsection but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such child, relative, or other individual, but only with respect to a State whose State plan approval under section 402 includes provision for—

[(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2);

[(B) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

[(C) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary;

[(D) aid in the form of foster home care in behalf of children described in section 408(a); and

[(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made;

[(c) The term "relative with whom any dependent child is living" means the individual who is one of the relatives specified in subsection (a) and with whom such child is living (within the meaning of such subsection) in a place of residence maintained by such individual (himself or together with any one or more of the other relatives so specified) as his (or their) own home.

[(d) The term "family services" means services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family, and such other services as will assist members of a family to attain or retain capability for the maximum self-support and personal independence.

[(e) (1) The term "emergency assistance to needy families with children" means any of the following, furnished for a period not in excess of 30 days in any 12-month period, in the case of a needy child under the age 21 who is (or, within such period as may be

specified by the Secretary, has been) living with any of the relatives specified in subsection (a) (1) in a place of residence maintained by one or more of such relatives as his or their own home, but only where such child is without available resources, the payments, care, or services involved are necessary to avoid destitution of such child or to provide living arrangements in a home for such child, and such destitution or need for living arrangements did not arise because such child or relative refused without good cause to accept employment or training for employment—

[(A) money payments, payments in kind, or such other payments as the State agency may specify with respect to, or medical care or any other type of remedial care recognized under State law on behalf of, such child or any other member of the household in which he is living, and

[(B) such services as may be specified by the Secretary; but only with respect to a State whose State plan approved under section 402 includes provision for such assistance.

[(2) Emergency assistance as authorized under paragraph (1) may be provided under the conditions specified in such paragraph to migrant workers with families in the State or in such part or parts thereof as the State shall designate.

Dependent Children of Unemployed Fathers

[Sec. 407. (a) The term “dependent child” shall, notwithstanding section 406(a), include a needy child who meets the requirements of section 406(a)(2), who has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of his father, and who is living with any of the relatives specified in section 406(a)(1) in a place of residence maintained by one or more of such relatives as his (or their) own home.

[(b) The provisions of subsection (a) shall be applicable to a State if the State’s plan approved under section 402—

[(1) requires the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

[(A) such child’s father has not been employed (as determined in accordance with the standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

[(B) such father has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

[(C) (i) such father has 6 or more quarters of work (as defined in subsection (d)(1)) in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) he received unemployment compensation under an unemployment compensation law of a State or of the United States, or he was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

[(2) provides—

[(A) for such assurances as will satisfy the Secretary that fathers of dependent children as defined in subsection (a) will be certified to the Secretary of Labor as provided in section 402(a)(19) within thirty days after receipt of aid with respect to such children;

[(B) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained; and

[(C) for the denial of aid to families with dependent children to any child or relative specified in subsection (a)—

[(i) if, and for so long as, such child's father is not currently registered with the public employment offices in the State, and

[(ii) with respect to any week for which such child's father receives unemployment compensation under an unemployment compensation law of a State or of the United States.

[(c) Notwithstanding any other provisions of this section, expenditures pursuant to this section shall be excluded from aid to families with dependent children (A) where such expenditures are made under the plan with respect to any dependent child as defined in subsection (a), (i) for any part of the 30-day period referred to in subparagraph (A) of subsection (b)(1), or (ii) for any period prior to the time when the father satisfies subparagraph (B) of such subsection, and (B) if, and for as long as, no action is taken (after the 30-day period referred to in subparagraph (A) of subsection (b)(2), under the program therein specified, to certify such father to the Secretary of Labor pursuant to section 402(a)(19).

[(d) For purposes of this section—

[(1) the term "quarter of work" with respect to any individual means a calendar quarter in which such individual received earned income of not less than \$50 (or which is a "quarter of coverage" as defined in section 213(a)(2)), or in which such individual participated in a community work and training program under section 409 or any other work and training program subject to the limitations in section 409, or the work incentive program established under part C;

[(2) the term "calendar quarter" means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31; and

[(3) an individual shall be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

[(A) he would have been eligible to receive such unemployment compensation upon filing application, or

[(B) he performed work not covered under such law and such work, if it had been covered, would (together with any

covered work he performed) have made him eligible to receive such unemployment compensation upon filing application.

[Federal Payments for Foster Home Care of Dependent Children

[Sec. 408. Effective for the period beginning May 1, 1961—

[(a) The term "dependent child" shall, notwithstanding section 406 (a), also include a child (1) who would meet the requirements of such section 406 (a) or of section 407, except for his removal after April 30, 1961, from the home of a relative (specified in such section 406 (a)) as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child, (2) whose placement and care are the responsibility of (A) the State or local agency administering the State plan approved under section 402, or (B) any other public agency with whom the State agency administering or supervising the administration of such State plan has made an agreement which is still in effect and which includes provision for assuring development of a plan, satisfactory to such State agency, for such child as provided in paragraph (f) (1) and such other provisions as may be necessary to assure accomplishment of the objectives of the State plan approved under section 402, (3) who has been placed in a foster family home or child-care institution as a result of such determination, and (4) who (A) received aid under such State plan in or for the month in which court proceedings leading to such determination were initiated, or (B) (i) would have received such aid in or for such month if application had been made therefor, or (ii) in the case of a child who had been living with a relative specified in section 406 (a) within six months prior to the month in which such proceedings were initiated, would have received such aid in or for such month if in such month he had been living with (and removed from the home of) such a relative and application had been made therefor;

[(b) the term "aid to families with dependent children" shall notwithstanding section 406 (b), include also foster care in behalf of a child described in paragraph (a) of this section—

[(1) in the foster family home of any individual, whether the payment therefor is made to such individual or to a public or nonprofit private child-placement or child-care agency, or

[(2) in a child-care institution, whether the payment therefor is made to such institution or to a public or nonprofit private child-placement or child-care agency, but subject to limitations prescribed by the Secretary with a view to including as "aid to families with dependent children" in the case of such foster care in such institutions only those items which are included in such term in the case of foster care in the foster family home of an individual;

[(c) the number of individuals counted under clause (A) of section 403 (a) (1) for any month shall include individuals (not otherwise included under such clause) with respect to whom expenditures were made in such month as aid to families with dependent children in the form of foster care; and

[(d) services described in paragraph (f) (2) of this section shall be considered as part of the administration of the State plan for purposes of section 403 (a) (3);

but only with respect to a State whose State plan approved under section 402—

[(e) includes aid for any child described in paragraph (a) of this section, and

[(f) (e) includes provision for (1) development of a plan for each such child (including periodic review of the necessity for the child's being in a foster family home or child-care institution) to assure that he receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed or to otherwise make possible his being placed in the home of a relative specified in section 406(a), and (2) use by the State or local agency administering the State plan, to the maximum extent practicable, in placing such a child in a foster family home or child-care institution, of the services of employees, of the State public-welfare agency referred to in section 522(a) (relating to allotments to States for child welfare services under part 3 of title V) or of any local agency participating in the administration of the plan referred to in such section, who perform functions in the administration of such plan.

[For the purposes of this section, the term "foster family home" means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing homes of this type, as meeting the standards established for such licensing; and the term "child-care institution" means a nonprofit private child-care institution which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing.

[Community Work and Training Programs

[Sec. 409. (a) For the purpose of assisting the States in encouraging, through community work and training programs of a constructive nature, the conservation of work skills and the development of new skills for individuals who have attained the age of 18 and are receiving aid to families with dependent children, under conditions which are designed to assure protection of the health and welfare of such individuals and the dependent children involved, expenditures (other than for medical or any other type of remedial care) for any month with respect to a dependent child (including payments to meet the needs of any relative or relatives, specified in section 406(a), with whom he is living) under a State plan approved under section 402 shall not be excluded from aid to families with dependent children because such expenditures are made in the form of payments for work performed in such month by any one or more of the relatives with whom such child is living if such work is performed for the State agency or any other public agency under a program (which need not be in effect in all political subdivisions of the State) administered by or under the supervision of such State agency, if there is State financial participation in such expenditures, and if such State plan includes—

[(1) provisions which, in the judgment of the Secretary, provide reasonable assurance that—

[(A) appropriate standards for health, safety, and other conditions applicable to the performance of such work by such relatives are established and maintained;

[(B) payments for such work are at rates not less than the minimum rate (if any) provided by or under State law for the same type of work and not less than the rates prevailing on similar work in the community;

[(C) such work is performed on projects which serve a useful public purpose, do not result either in displacement of regular workers or in the performance by such relatives of work that would otherwise be performed by employees of public or private agencies, institutions, or organizations, and (except in cases of projects, which involve emergencies or which are generally of a nonrecurring nature) are of a type which has not normally been undertaken in the past by the State or community, as the case may be;

[(D) in determining the needs of any such relative, any additional expenses reasonably attributable to such work will be considered;

[(E) any such relative shall have reasonable opportunities to seek regular employment and to secure any appropriate training or retraining which may be available;

[(F) any such relative will, with respect to the work so performed, be covered under the State workmen's compensation law or be provided comparable protection; and

[(G) aid under the plan will not be denied with respect to any such relative (or the dependent child) for refusal by such relative to perform any such work if he has good cause for such refusal;

[(2) provision for entering into cooperative arrangements with the system of public employment officers in the State looking toward employment or occupational training of any such relatives performing work under such program, including appropriate provision for registration and periodic reregistration of such relatives and for maximum utilization of the job placement services and other services and facilities of such offices;

[(3) provision for entering into cooperative arrangements with the State agency or agencies responsible for administering or supervising the administration of vocational education and adult education in the State, looking toward maximum utilization of available public vocational or adult education services and facilities in the State in order to encourage the training or retraining of any such relatives performing work under such program and otherwise assist them in preparing for regular employment;

[(4) provision for assuring appropriate arrangements for the care and protection of the child during the absence from the home of any such relative performing work under such program in order to assure that such absence and work will not be inimical to the welfare of the child;

[(5) provision that there be no adjustment or recovery by the State or any political subdivision thereof on account of any payments which are correctly made for such work; and

[(6) such other provisions as the Secretary finds necessary to assure that the operation of such program will not interfere with achievement of the objectives set forth in section 401.

[(b) In the case of any State which makes expenditures in the form described in subsection (a) under its State plan approved under section 402, the proper and efficient administration of the State plan, for purposes of section 403(a) (3) and (4) may not include the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in subsection (a) or the cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.

[Assistance by Internal Revenue Service in Locating Parents

[Sec. 410. (a) Upon receiving a report from a State agency made pursuant to section 402(a) (21), the Secretary shall furnish to the Secretary of the Treasury or his delegate the names and social security account numbers of the parents contained in such report, and the name of the State agency which submitted such report. The Secretary of the Treasury or his delegate shall endeavor to ascertain the address of each such parent from the master files of the Internal Revenue Service, and shall furnish any address so ascertained to the State agency which submitted such report.

[(b) There are hereby authorized to be appropriated such sums as may be necessary to carry out the provisions of subsection (a). The Secretary shall transfer to the Secretary of the Treasury from time to time sufficient amounts out of the monies appropriated pursuant to this subsection to enable him to perform his functions under subsection (a).]

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

Appropriation

SEC. 401. For the purposes of (1) encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State, to the extent it deems appropriate under State law, to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditions in such State, to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, (2) aiding in obtaining support payments for such children from absent parents, and (3) aiding in the determination of the paternity of such children who are born out of wedlock, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to families with dependent children.

*SUBPART 1—STATE PLANS FOR AID TO FAMILIES
WITH DEPENDENT CHILDREN*

General Administrative Provisions

SEC. 402. A State plan for aid to families with dependent children must—

(a) *provide that, except to the extent permitted by the Secretary with respect to services under section 407, it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;*

(b) *provide for financial participation by the State;*

(c) *provide for the establishment or designation of a single State agency either to administer the plan or to supervise the administration of the plan;*

(d) *set forth the methods of administration to be followed in carrying out the State plan which—*

(1) *include methods relating to the establishment and maintenance of personnel standards on a merit basis, and*

(2) *provide for the training and effective use of paid sub-professional staff, with particular emphasis on the full-time or part-time employment of recipients of public assistance → , participants in the employment program operated pursuant to title XX, ←¹ and other persons of low income, as community services aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients;*

(e) *provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;*

(f) *provide for prompt notice (including the transmittal of all relevant information) to the Attorney General of the United States (or the appropriate State official or agency (if any) designated by him pursuant to part D) of the furnishing of aid to families with dependent children with respect to a child who has been deserted or abandoned by a parent (including a child born out of wedlock without regard to whether the paternity of such child has been established);*

(g) *provide (1) that, as a condition of eligibility under the plan, each applicant for or recipient of aid shall furnish to the State agency his social security account number (or numbers, if he has more than one such number), and (2) that such State agency shall utilize such account numbers, in addition to any other means of identification it may determine to employ, in the administration of such plan;*

(h) (1) *provide that, as a condition of eligibility for aid, each applicant or recipient will be required to assign to the United States any rights to support from any other person he may have—*

¹ Amendment appearing between arrows effective January 1, 1974.

(i) in his own behalf or in behalf of any other family members for whom he is applying for or receiving aid, and

(ii) which have accrued at the time such assignment is executed, and which will accrue during the period ending with the third month following the month in which he (or such other family members) will have received aid under the plan or with such later month as may be determined under section 455(b); and

(2) contain such provisions pertaining to determining paternity and securing support and locating absent parents as are prescribed by the Attorney General of the United States in order to comply with the requirements of part D;

(i) provide—

(1) that aid to families with dependent children shall not be furnished to any individual unless such individual (A) is a resident of the State, and (B) has resided in the State continuously for ninety consecutive days immediately preceding the application for such aid;

(2) that such aid shall be furnished under the State plan for a period of ninety consecutive days to any individual who (A) has moved out of such State regardless of whether he has terminated his residence in such State, (B) was receiving aid under such State plan in the month before the month in which he moved out of such State, (C) continues to meet the eligibility requirements of such State plan except for residency, and (D) is not receiving aid to families with dependent children under a plan of the State in which he is present solely because he does not meet the duration of residency requirements imposed under subclause (1);

(3) that for the purpose of furnishing aid under the State plan to any individual described in subclause (2), appropriate agreements (including provisions for reimbursement) will be made with the State agency administering or supervising the administration of the plan approved under this part of the other State so that the agency of such other State will determine the continuing eligibility of and make payments to such individual; and

(4) that the State agency will enter into agreements with the State agency administering or supervising the administration of the plan under this part of other States to carry out for them the functions described in subclause (3); and

(j) provide that, if the State plan contains provisions limiting to a specified period of time eligibility of individuals for aid under the plan based on any approved application for such aid, such period of time shall not be less than two years; and provide that the right of any individual, whose eligibility for such aid is affected by such provisions, to reapply for such aid shall not be adversely affected by reason of such provisions.

At the option of the State, the State plan for aid to families with dependent children may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this part.

Eligibility for Aid to Families With Dependent Children

SEC. 403. A State plan for aid to families with dependent children must provide that such aid will be furnished to all individuals who apply and are determined to be eligible therefor under such plan.

Determining Eligibility and Amount of Aid

SEC. 404. A State plan for aid to families with dependent children—

(a) must provide that aid furnished for any month under the plan shall not be less than—

- (1) \$66.67, in the case of a family with one member,*
- (2) \$133.33, in the case of a family with two members,*
- (3) \$166.67, in the case of a family with three members,*

and

- (4) \$200.00, in the case of a family with four or more members,*

(or, if less, the amount which a family of such size with no other income would have received for June 1972 under the State plan approved under this part) reduced by all income not required to be disregarded by clause (d);

(b) must provide that eligibility for aid to families with dependent children will not be determined solely on the basis of declarations concerning eligibility factors and other relevant facts by an applicant for or recipient of such aid, and that relevant information will be verified to the maximum extent feasible from independent or collateral sources and additional information obtained as necessary in order to insure that such aid is only provided to eligible persons and that the amounts of such aid are correct;

(c) except as otherwise provided in clause (d), must provide that the State agency shall, in determining need, take into consideration any other income or resources of any child or relative claiming aid to families with dependent children or of any other individual whose needs the State determines should be considered in determining the need of the child or relative claiming such aid, but in no event will the needs of any other individual be considered for purposes of making the determination under this clause (c) unless such individual is—

- (1) living in the same home as such child and relative, and*
- (2) one of the relatives of such child specified in section 411(a)(1)(A) (but not including a brother, sister, step-brother, or step-sister of such child who does not meet the requirements of section 411(a)(1)(A)(ii));*

(d) must provide that, in making the determination under clause (c), the State agency—

[*(1) shall with respect to any month disregard—*

[*(A) all of the earned income of each dependent child receiving aid to families with dependent children who is a full-time student or part-time student who is not a full-time employee attending a school, college, or uni-*

versity, or a course of vocational or technical training designed to fit him for gainful employment,

[(B) in the case of the earned income of a dependent child not included in subclause (1) (A), a relative receiving such aid, and any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$60 (or, if such individual is not working at least 40 hours per week, or at least 35 hours per week and earning per week an amount at least equal to 40 times the hourly minimum wages specified in section 6 (a) (1) of the Fair Labor Standards Act of 1938, the first \$30) of such earned income for such month, plus one-third of the next \$300 of such income for such month, plus one-fifth of the remainder of such income for such month, except that (i) reasonable child care expenses (subject to such limitations as the Secretary may prescribe in regulations) will first be deducted before computing such individual's earned income and (ii) the provisions of this subclause (1) (B) shall not apply to earned income derived from participation on a project maintained under the program established by section 408 or by clause (2) or (3) of section 432 (b), and

[(C) \$20 per month, with respect to the dependent child (or children), relative with whom the child (or children) are living, and other individual (living in the same home as such child (or children)) whose needs are taken into account in making such determination, of all income derived from support payments collected pursuant to part D; and

[(2) (A) may, subject to the limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child, and (B) may, before disregarding the amounts referred to in subclause (1) and subclause (2) (A), disregard not more than \$5 per month of any income;

except that, with respect to any month, the State agency shall not disregard any earned income (other than income referred to in subclause (2)) of—

[(3) any one of the persons specified in subclause (1) (B) if such person—

[(A) terminated his employment or reduced his earned income without good cause within such period (of not less than 30 days) preceding such month as may be prescribed by the Secretary; or

[(B) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State or local

agency administering the State plan, after notification by him, to be a bona fide offer of employment; or

[(4) any of such persons specified in subclause (1) (B) if with respect to such month the income of the persons so specified (within the meaning of clause (c)) was in excess of their need as determined by the State agency pursuant to clause (c) (without regard to this clause (d)) unless, for any one of the four months preceding such month, the needs of such person were not met by the furnishing of aid under the plan;¹

→ (d) must provide that, in making the determination under clause (c) —

(1) the State agency shall, with respect to any month, disregard \$20, with respect to the dependent child (or children), relative with whom the dependent child (or children) is living, and other individual (living in the same home as such child (or children)) whose needs are taken into account in making such determination, of all income derived from support payments collected pursuant to part D;

(2) in the case of a family other than a family headed by an employable person (as defined in section 411(g)), the State agency shall, with respect to any month, disregard (in addition to any amount disregarded pursuant to subclause (1)) \$20 of any income other than (i) income derived from support payments collected pursuant to part D or (ii) income paid to any member of such family on the basis of the need of such member or family; and

(3) in the case of a family headed by an employable person or of a family with earned income in excess of \$200 per month, that portion of the earned income of such family (regardless of whether such family headed by an employable person does in fact receive any such income) for any month which is not in excess of \$300 (or, if the minimum wage specified in section 6(a)(1) of the Fair Labor Standards Act of 1938 exceeds \$1.60 per hour, 187.5 times such minimum wage, but in no event more than \$375), shall be counted for purposes of this part as \$200 of such income for such month; ←²

(e) may provide for the State agency to make rent payments for any month directly to a public housing agency on behalf of an individual or family receiving aid under the plan or on behalf of groups of such individuals or families, and that the State agency may make rent payments directly to any private person on behalf of an individual or family receiving aid under the plan, and that if the State plan provides for such payments to private persons, such payments will be made only if (1) such individual or family has failed without good cause under State law to make rent payments for which he was obligated, whether or not to his or their current landlord, for any two consecutive months within the twelve-month period immediately preceding the month for which the State agency commences to make such rent payments, (2) such rent payments with respect to such individual or family are

¹ Section 404(d) above is deleted January 1, 1974.

² Section 404(d) appearing between arrows effective January 1, 1974.

for any month equal to the least of (A) the amount of aid under the plan for which such individual or family is eligible for such month, (B) the full rent owed by such individual or family for such month, or (C) the amount used by the State for such month to determine the need for rent of an individual or family (of the same size as such family) with no income other than aid under the State plan, and (3) such person agrees to accept the payment by the State agency of the amount described in subclause (2) (B) or (2) (C) as the full rent owed for such month; and

(f) must provide that in any case in which more or less than the correct amount of aid for any month was paid with respect to a family under the plan,

(1) in the case of underpayments, proper adjustment shall be made in future payments with respect to such family which are made within such maximum period of time as the State agency may prescribe, and

(2) in the case of overpayments—

(A) proper adjustment or recovery shall be made by adjustment in future payments with respect to such family or by recovery from such family in accordance with procedures of the State for collection of overpayments.

or

(B) if such adjustment or recovery cannot be made, the State agency will so notify the Secretary so that he may make appropriate adjustments to or recovery from other amounts which may be owed to any member of such family by the United States pursuant to section 414.

Statutory Rights of Applicants for and Recipients of Aid to Families With Dependent Children

SEC. 405. A State plan for aid to families with dependent children must—

(a) provide that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that such aid will only be furnished to or with respect to eligible persons (as defined in section 411(f)) and will, subject to subsections (g), (h), and (i) of section 402, subsections (b) and (f) of section 404, and subsections (a) and (e) of section 409, be furnished with reasonable promptness;

(b) provide (1) for granting an opportunity for an evidentiary hearing before the State agency or, if the State plan is administered in each of the political subdivisions of the State by a local agency, before such local agency, to any individual whose claim for aid to families with dependent children is denied, or is not acted upon with reasonable promptness or to any individual who is receiving aid under the plan which aid such State or local agency determines should be terminated or the amount of which should be reduced, (2) that any hearing held at the request of any individual to determine the matter of whether the aid provided to such individual (or to members of his family) under the State plan should be terminated, or the amount thereof reduced shall be com-

pleted and the agency before which such hearing is held shall make a decision on the basis of such evidentiary hearing with respect to such matter not later than thirty days after the date such individual is notified of the intention of such agency to terminate or reduce the amount of such aid, (3) that the agency before which such hearing is held may put its decision into effect immediately upon its issuance, (4) that if the evidentiary hearing is held by a local agency administering the State plan in a political subdivision of such State, the individual will be provided an opportunity to appeal such decision to the State agency, and (5) if any individual (or family) is determined under a final decision of the State agency (or of the local agency if no appeal is taken therefrom) to have received, prior to such decision, aid under the plan in any amount to which he (or his family) was not entitled, appropriate adjustment or recovery of such amount will be made as required by section 404(f); except that no individual whose eligibility for aid under the State plan is terminated by reason of the provisions (referred to in section 402(j) and relating to limitation of duration of eligibility based on any approved application for aid) in a State plan shall be entitled to a hearing on account of termination of his eligibility arising from the application of such provisions; and

(c) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (1) to public officials who require such information in connection with their official duties, or (2) to other persons for purposes directly connected with the administration of aid to families with dependent children.

Protection of Children

SEC. 406. (a) A State plan for aid to families with dependent children must—

(1) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child, it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, and shall provide such data with respect to the situation as it may have;

(2) provide that, whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency shall provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and shall provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as defined in subsection (b), or in seeking appointment of a guardian or legal representative as provided in section 1111, or in the imposition of criminal or civil pen-

alties authorized under State law if it is determined by a court of competent jurisdiction that such relative is not using or has not used for the benefit of the child such payments made for that purpose; and the provision of such services or advice by the State agency (or the taking of the action specified in such advice) shall not serve as a basis for withholding funds from such State under section 413 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children;

(3) provide for aid to families with dependent children in the form of foster care, including provision for—

(A) development of a plan for each such child (including periodic review of the necessity for the child's being in a foster family home or child-care institution) to assure that he receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed or to otherwise make possible his being placed in the home of a relative specified in section 411(a)(1), and

(B) use by the State or local agency administering the State plan, to the maximum extent practicable, in placing such a child in a foster family home or child-care institution, of the services of employees of the State public-welfare agency referred to in section 421(a) (relating to allotments to States for child welfare services under part B) or of any local agency participating in the administration of the plan referred to in such section, who perform functions in the administration of such plan; and

(4) provide that protective payments (as defined in subsection (b) but without regard to paragraphs (1) through (5) thereof) will be made to meet the needs of a dependent child in any case in which the relative with whom such child is living is not an eligible person by reason of—

[(A) his refusal to accept employment or to participate in any employment or training program if his acceptance or participation is otherwise required by this part.]¹

(B) her failure to cooperate with any official or agency of the State or of the United States in establishing the paternity of such child (where such relative is the mother of a dependent child born out of wedlock), or in obtaining support payments for herself or such child,

(C) a medical determination that such relative is a drug addict or alcoholic if and for so long as he is not receiving payment directly under title XV, or

(D) his failure to agree to permit inspection of the home in which such relative lives, at reasonable times and with reasonable notice, by a duly authorized person employed by or on behalf of such State in the administration of the State plan approved under this part.

(b) For purposes of this part, the term "protective payments" means payments with respect to any dependent child (including payments to

¹ This subsection 406(a)(4)(A) is deleted January 1, 1974.

meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 404(c) which are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child, relative, or other individual, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such child, relative, or other individual, but only with respect to a State whose State plan approved under this part includes provision for—

(1) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the best interests of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this subsection (b);

(2) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

(3) periodic review by such State agency of the determination under clause (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified in regulations prescribed by the Secretary;

(4) aid in the form of foster home care in behalf of children described in section 411(a)(3); and

(5) opportunity for an evidentiary hearing before the State agency or, if the State plan is administered in each of the political subdivisions of the State by a local agency, before such local agency on the determination referred to in clause (1) for any individual with respect to whom it is made;

but such term does not include any amount to meet the needs of an individual who is not an eligible person.

Social Services

SEC. 407. (a) A State plan for aid to families with dependent children must—

(1) provide a description of the services to families with dependent children which the State agency (using whatever internal organizational arrangement it finds appropriate for this purpose) makes available to maintain and strengthen family life for children, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(2) provide, in such cases as the State agency finds appropriate, for the development and application of a program for such services to families with dependent children, as defined in subsection (b), for each child and relative who receives aid to families with

dependent children, and each appropriate individual (living in the same home as a relative and child receiving such aid whose needs are taken into account in making the determination under section 404(c)), as may be necessary in the light of the particular home conditions and other needs of such child, relative, and individual, in order to assist such child, relative, and individual to attain or retain capability for self-support and care and in order to maintain and strengthen family life and to foster child development;

(3) provide for the development of a program for each appropriate relative and dependent child receiving aid under the plan, and each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under section 404(c), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases family planning services (including supplies) are offered them and are provided promptly to all individuals requesting such services, but acceptance by such child, relative, or individual of family planning services under the plan shall be voluntary on the part of such child, relative, or individual and shall not be a prerequisite to eligibility for or the receipt of any other service or aid under the plan; and

(4) provide that to the extent that services provided under the State plan are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services; and

(5) provide for the referral to the State or appropriate local agency administering the plan of such State approved under title XV of any individual applying for aid to families with dependent children who is medically determined to be a drug addict or alcoholic but who otherwise would be eligible for such aid under the State plan approved under this part.

(b) The term "services to families with dependent children" means services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family, and such other services as will assist members of a family to attain or retain capability for the maximum self-support and personal independence.

[Community Work and Training Programs¹

[SEC. 408. (a) For the purpose of assisting the States in encouraging, through community work and training programs of a constructive nature, the conservation of work skills and the development of new skills for relatives with whom a dependent child is living and other individuals whose needs are taken into account in making the determination under section 404(c) and who are receiving aid to families with dependent children, under conditions which are designed to assure

¹ Section 408 of this Act is repealed January 1, 1974.

protection of the health and welfare of such individuals and the dependent children involved, expenditures (other than for medical or any other type of remedial care) for any month with respect to a dependent child (including payments to meet the needs of any relative or relatives, specified in section 411(a)(1)(A), with whom he is living) under a State plan approved under this part shall not be excluded from aid to families with dependent children because such expenditures are made in the form of payments for work performed in such month by any one or more of the relatives specified in section 411(a)(1)(A) with whom such child is living if such work is performed for the State agency or any other public agency under a program (which need not be in effect in all political subdivisions of the State) administered by or under the supervision of such State agency, if there is State financial participation in such expenditures, and if such State plan includes—

[(1) provisions which, in the judgment of the Secretary, provide reasonable assurance that—

[(A) appropriate standards for health safety, and other conditions applicable to the performance of such work by such relatives are established and maintained;

[(B) payments for such work are at rates not less than the minimum rate (if any) provided by or under State law for the same type of work and not less than the rates prevailing on similar work in the community;

[(C) such work is performed on projects which serve a useful public purpose, do not result either in displacement of regular workers or in the performance by such relatives of work that would otherwise be performed by employees of public or private agencies, institutions, or organizations, and (except in cases of projects which involve emergencies or which are generally of a nonrecurring nature) are of a type which has not normally been undertaken in the past by the State or community, as the case may be;

[(D) in determining the needs of any such relative, any additional expenses reasonably attributable to such work will be considered;

[(E) any such relative shall have reasonable opportunities to seek regular employment and to secure any appropriate training or retraining which may be available; and

[(F) aid under the plan will not be denied with respect to any such relative (or the dependent child) for refusal by such relative to perform any such work if he has good cause for such refusal;

[(2) provision for entering into cooperative arrangements with the system of public employment offices in the State looking toward employment or occupational training of any such relatives performing work under such program, including appropriate provision for registration and periodic reregistration of such relatives and for maximum utilization of the job placement services and other services and facilities of such offices;

[(3) provision for entering into cooperative arrangements with the State agency or agencies responsible for administering or supervising the administration of vocational education and adult

education in the State, looking toward maximum utilization of available public vocational or adult education services and facilities in the State in order to encourage the training or retraining of any such relatives performing work under such program and otherwise assist them in preparing for regular employment;

[(4) *provision for assuring appropriate arrangements for the care and protection of the child during the absence from the home of any such relative performing work under such program in order to assure that such absence and work will not be inimical to the welfare of the child;*

[(5) *provision that there will be no adjustment or recovery by the State or any political subdivision thereof on account of any payments which are correctly made for such work; and*

[(6) *such other provisions as the Secretary finds necessary to assure that the operation of such program will not interfere with achievement of the objectives set forth in section 401.*

[(b) *In the case of any State which makes expenditures in the form described in subsection (a) under its State plan approved under this part, the proper and efficient administration of the State plan, for purposes of section 412(a)(3) may not include the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in subsection (a) or the cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.*]¹

[Relationship With Work Incentive Program²

[Sec. 409. *A State plan for aid to families with dependent children must provide—*

[(a) *that every individual, as a condition of eligibility for aid under this part, shall register for manpower services, training, and employment as provided by regulations of the Secretary of Labor, unless such individual is—*

[(1) *a child who is under age 16 or attending school full time;*

[(2) *a person who is ill, incapacitated, or of advanced age;*

[(3) *a person so remote from a work incentive project that his effective participation is precluded,*

[(4) *a person whose presence in the home is required because of illness or incapacity of another member of the household;*

[(5) *a mother or other relative of a child under the age of six who is caring for the child; or*

[(6) *the mother or other female caretaker of a child, if the father or another adult male relative is in the home and not excluded by subclause (1), (2), (3), or (4) of this clause (unless he has failed to register as required by this clause, or has been found by the Secretary of Labor under section 433(g) to have refused without good cause to participate under a*

¹ Section 408 of this Act is repealed January 1, 1974.

² Section 409 of this Act (including the heading), is deleted January 1, 1974, and substituted by the next following section 409 appearing immediately below.

work incentive program or accept employment as described in clause (e) of this section);
and that any individual referred to in subclause (5) shall be advised of her option to register, if she so desires, pursuant to this paragraph, and shall be informed of the child care services (if any) which will be available to her in the event she should decide so to register;

[(b) *that aid under the plan will not be denied by reason of such registration or the individual's certification to the Secretary of Labor under clause (f) of this section, or by reason of an individual's participation on a project under the program established by section 432(b) (2) or (3) so long as, in making the determination required under section 404(c), the State agency finds that such individual (and his family) remain eligible for such aid;*

[(c) *for arrangements to assure that there will be made a non-Federal contribution to the work incentive programs established by part C by appropriate agencies of the State or private organizations of 10 per centum of the cost of such programs, as specified in section 435(b);*

[(d) *that (1) training incentives authorized under section 434 shall be disregarded in determining the needs of an individual under section 404(c), and (2) in determining such individual's needs the additional expenses attributable to his participation in a program established by section 432(b) (2) or (3) shall be taken into account;*

[(e) *that if and for so long as any child, relative, or individual (certified to the Secretary of Labor pursuant to clause (f)) has been found by the Secretary of Labor under section 433(g) to have refused without good cause to participate under a work incentive program established by part C with respect to which the Secretary of Labor has determined his participation is consistent with the purposes of such part C, or to have refused without good cause to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined, after notification by him, to be a bona fide offer of employment—*

[(1) *if the relative makes such refusal, such relative's needs shall not be taken into account in making the determination under section 404(c), and aid for any dependent child in the family in the form of protective payments as defined in section 406(b) (which in such a case shall be without regard to clauses (1) through (5) thereof) or section 406(a) (3) will be made;*

[(2) *aid with respect to a dependent child will be denied if a child who is the only child receiving aid in the family makes such refusal;*

[(3) *if there is more than one child receiving aid in the family, aid for any such child will be denied (and his needs will not be taken into account in making the determination under section 404(c)) if that child makes such refusal; and*

[(4) *if such individual makes such refusal, such individ-*

ual's needs will not be taken into account in making the determination under section 404(c); except that the State agency shall for a period of sixty days, make payments of the type described in section 406(b) (without regard to clauses (1) through (5) thereof) on behalf of the relative specified in subclause (1), or continue aid in the case of a child specified in subclause (2) or (3), or take the individual's needs into account in the case of an individual specified in subclause (4), but only if during such period such child, relative, or individual accepts counseling or other services (which the State agency shall make available to such child, relative, or individual) aimed at persuading such child, relative, or individual, as the case may be, to participate in such program in accordance with the determination of the Secretary of Labor; and

[*(f) that the State agency will have in effect a special program which (1) will be administered by a separate administrative unit and the employees of which will, to the maximum extent feasible, perform services only in connection with the administration of such program, (2) will provide (through arrangements with others or otherwise) for individuals who have been registered pursuant to clause (a), in accordance with the order of priority listed in section 433(a), such health, vocational rehabilitation, counseling, child care, and other social and supportive services as are necessary to enable such individuals to accept employment or receive manpower training provided under part C, and will, when arrangements have been made to provide necessary supportive services, including child care, certify to the Secretary of Labor those individuals who are ready for employment or training under part C, (3) will participate in the development of operational and employability plans under section 433(b), and (4) will provide for purposes of clause (2), that, when more than one kind of child care is available, the mother may choose the type, but she may not refuse to accept child care services if they are available.***]**

→Relationship With Employment Program¹

→SEC. 409. *A State plan for aid to families with dependent children must provide that, in the case of any family which is headed by an employable person (as defined in section 411(g)) who is a mother (described in paragraph (2) of section 411(g)) who is applying for or receiving aid under the plan, and refuses to participate in the employment program operated pursuant to title XX, if and for so long as any such refusal continues after the close of the thirty-day period during which the Work Administration has provided appropriate counseling pursuant to section 2056(b), such person's needs shall not be taken into account in making the determination under section 404(c); she shall not be considered a member of the family for purposes of section 404(d)(3), and aid for any dependent child in the family in the form of payments of the type described in section 406(b) (which in such a case shall be without regard to clauses (1) through (5) thereof) or section 406(a)(3) will be made, and if such person is a recipient at the time of her refusal, the State agency shall—*

¹ Section 409 (including the heading) appearing between arrows, effective January 1, 1974.

→(1) if, at the end of such thirty days, she has not agreed to participate in such program, determine whether she is incapacitated, and, if so, refer her to the State agency administering the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act and require that, as a condition of eligibility for aid to families with dependent children, she accept such rehabilitation services as are made available to her under such State plan, and

→(2) if such person refuses to accept vocational rehabilitation services following a referral pursuant to subclause (1) or is determined not to be incapacitated and refuses to participate in such employment program, such person shall not be considered an eligible person and payments of the type described in section 406(b) (which in such a case shall be made without regard to clauses (1) through (5) thereof) or section 406(a)(3) shall be made with respect to the dependent children living with such person.←¹

Emergency Assistance

SEC. 410. (a) A State plan for aid to families with dependent children—

(1) may provide emergency assistance to needy families with children (as defined in subsection (b)), and

(2) must provide emergency assistance to needy families with children (as so defined), on a statewide basis, to needy migrant workers with children in the State.

(b) The term “emergency assistance to needy families with children” means any of the following, furnished for a period not in excess of 30 days in any 12-month period, in the case of a needy child under age 21 who is (or, within such period as may be specified in regulations prescribed by the Secretary, has been) living with any of the relatives specified in section 411(a)(1)(A) in a place of residence maintained by one or more of such relatives as his or their own home, but only where such child is without available resources, the payments, care, or services involved are necessary to avoid destitution of such child or to provide living arrangements in a home for such child, and such destitution or need for living arrangements did not arise because such child or relative refused without good cause to accept employment or training for employment:

(1) money payments, payments in kind, or such other payments as the State agency may specify with respect to, or medical care or any other type of remedial care recognized under State law on behalf of, such child or any other member of the household in which he is living, and

(2) such services as may be specified in regulations prescribed by the Secretary

SUBPART 2—DEFINITIONS

SEC. 411. When used in this part—

(a)(1)(A) The term “dependent child” means a needy child who has been born and (i) who has been deprived of parental support or

¹Section 409 (including the heading) appearing between arrows, effective January 1, 1974.

care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives at his or their own home, and (ii) who is (I) under the age of eighteen or (II) under the age of twenty-one and (as determined by the State) a student regularly attending a school, college, or university, or (III) under the age of twenty-one and (as determined by the State) a student regularly attending a course of vocational or technical training designed to fit him for gainful employment.

(B) (i) The term "parent", when used with respect to any child, means such child's natural parent or his adoptive parent, and, at the option of the State, may also include (I) his stepparent, or (II) if such child's father or stepfather is deceased or continuously absent from the home, any other adult individual (regardless of whether such other individual is living in the same home as such child and the relative with whom the child is living) if and for so long as there exists a continuing parent-child type relationship between such child and such individual if such individual is not the grandfather, grandmother, brother, sister, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece of such child, but no child shall be found to be deprived of parental support or care by reason of the continued absence from the home of such individual.

(ii) For purposes of determining whether a continuing parent-child type relationship exists between a child and such an adult individual, only the following factors may be taken into account: (I) the frequency with which such child and such individual appear together in public, (II) whether such individual is the parent of a half brother or half sister of such child, (III) whether such individual exercises parental control over such child, (IV) whether substantial gifts are made by such individual to such child or to members of the family of such child, (V) whether such individual claims such child as a dependent for income tax purposes, (VI) whether such individual cares for or arranges for the care of such child when the relative with whom such child is living is ill or absent from home, (VII) whether such individual assumes responsibility for such child when a crisis occurs in such child's life, such as illness or detention of such child by public authorities, (VIII) whether such individual is listed as the parent or guardian of such child in school records which are designed to indicate the parents or guardians of children, (IX) whether such individual makes frequent visits to such household, (X) whether such individual gives or uses as his address the address of such household in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations. Such a relationship may be determined to exist in any case only after an evaluation of the factors specified in the preceding sentence, as well as any evidence which may refute any inference supported by evidence related to such factors.

(2) (A) At the option of the State, the term "dependent child" may include a needy child who meets the requirements of section 411(a) (1) (A) (ii), who has been deprived of parental support or care by reason of the unemployment (as determined in accordance with stand-

ards prescribed by the Secretary) of his father, and who is living with any of the relatives specified in section 411(a)(1)(A) in a place of residence maintained by such relative (himself or together with any one or more of the other relatives so specified) as his (or their) own home; Provided, that for purposes of this subparagraph, an individual who is the father of a dependent child shall not be considered to be unemployed for any week in which his unemployment is on account of a labor dispute at the establishment where he was previously employed, unless such individual (1) is not directly interested in and has not participated in such dispute, and (2) is not a member of any group of employees which is directly interested in, financing or participating in, such dispute.

(B) The provisions of subparagraph (A) shall be applicable to a State if the State's plan approved under this part—

(i) requires the payment of aid to families with dependent children with respect to a dependent child as defined in subparagraph (A) when—

(I) such child's father has not been employed (as determined in accordance with standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(II) such father has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training, and

(III) (a) such father has 6 or more quarters of work (as defined in subparagraph (D)(i)) in any 13-calendar-quarter period ending within one year prior to the application for such aid or (b) he received unemployment compensation under an unemployment compensation law of a State or of the United States, or he was qualified (within the meaning of subparagraph (D)(iii)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid: and

(ii) provides—

(I) for such assurances as will satisfy the Secretary that fathers of dependent children as defined in subparagraph (A) will be certified to the Secretary of Labor as provided in section 409 within 30 days after the receipt of aid with respect to such children;

(II) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained; and

(III) for the denial of aid to families with dependent children to any child or relative specified in subparagraph (A) if, and for as long as, such child's father—

(a) is not currently registered with the public employment offices in the State, or

(b) receives unemployment compensation under an unemployment compensation law of a State or of the United States.

(C) For purposes of this section—

(i) the term “quarter of work” with respect to any individual means a calendar quarter in which such individual received earned income of not less than \$50 (or which is a “quarter of coverage” as defined in section 213(a)(2)), or in which such individual participated in a community work and training program under section 408 or any other work and training program subject to the limitations in section 408, or the work incentive program established under part C;

(ii) the term “calendar quarter” means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31; and

(iii) an individual shall be deemed qualified for unemployment compensation under the State’s unemployment compensation law if—

(I) he would have been eligible to receive such unemployment compensation upon filing application, or

(II) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application.

(3) The term “dependent child” shall also include a child (A) who would meet the requirements of paragraph (1) or (2) except for his removal from the home of a relative (specified in such paragraph (1)) as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child, (B) whose placement and care are the responsibility of (i) the State or local agency administering the State plan approved under this part, or (ii) any other public agency with whom the State agency administering or supervising the administration of such State plan has made an agreement which is still in effect and which includes provision for assuring development of a plan, satisfactory to such State agency, for such child as provided in section 406(a)(3)(A) and such other provisions as may be necessary to assure accomplishment of the objectives of the State plan approved under this part, (C) who has been placed in a foster family home or child-care institution as a result of such determination, and (D) who (i) received aid under such State plan in or for the month in which court proceedings leading to such determination were initiated; or (ii) (I) would have received such aid in or for such month if application had been made therefor, or (II) in the case of a child who had been living with a relative specified in paragraph (1)(A) within 6 months prior to the month in which such proceedings were initiated, would have received such aid in or for such month if in such month he had been living with (and removed from the home of) such a relative and application had been made therefor.

(b) The term “aid to families with dependent children”—

(1) means money payments, rent payments meeting the requirements of section 404(e), and protective payments as defined in section 406(b), with respect to a dependent child or dependent

children and includes any such payments to meet the needs of the relative with whom the child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 411(a)(2)); and

(2) also includes foster care in behalf of a child described in paragraph (a)(3) of this section—

(A) in the foster family home of any individual, whether the payment therefor is made to such individual or to a public or nonprofit private child-placement or child-care agency, or

(B) in a child-care institution (other than one which meets the definition contained in section 2118), whether the payment therefor is made to such institution or to a public or nonprofit private child-placement or child-care agency, but subject to limitations prescribed by the Secretary with a view to including as "aid to families with dependent children" in the case of such foster care in such institutions only those items which are included in such term in the case of foster care in the foster family home of an individual.

(c) The term "relative with whom any dependent child is living" means the individual who is one of the relatives specified in subsection (a)(1) and with whom such child is living (within the meaning of such subsection) in a place of residence maintained by such individual (himself or together with any one or more of the other relatives so specified) as his (or their) own home.

(d) The term "foster family home" means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing homes of this type, as meeting the standards established for such licensing; and the term "child-care institution" means a nonprofit private child-care institution which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing.

(e) The term "physical or mental incapacity" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment.

(f) The term "eligible person", in the case of any State, means a dependent child, a relative with whom any dependent child is living, or any other individual (living in the same home as such a child and relative) whose needs such State determines should be considered in determining the need of the child or relative claiming aid under the plan of such State approved under this part, except such term does not include any such child, relative, or individual who for any month—

(1) (other than a member of a migrant family, for purposes of emergency assistance under section 410) has resided in such State for a period of less than 90 consecutive days or, in the case of a child born within three months immediately preceding the application for such aid, is living with a parent or other relative who has resided in such State for a period of less than 90 consecutive days;

(2) is neither a citizen nor an alien lawfully admitted for permanent residence (or otherwise permanently residing in the United States under color of law);

(3) is outside the United States during all of such month (and an individual who has been outside the United States for any period of 30 consecutive days shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days);

(4) is a mother of a child born out of wedlock with respect to whom such aid is claimed and who fails to cooperate with the State agency or with the United States in establishing the paternity of such child;

(5) is the parent of a child with respect to whom such aid is claimed who fails to cooperate with any agency or official of the State or of the United States in obtaining support payments for herself or such child or in obtaining any other payments or property due herself or such child;

(6) is medically determined to be a drug addict or alcoholic;

(7) is, prior to January 1, 1974, receiving aid under title, XVI, or after December 31, 1973 is receiving supplemental security income benefits under such title;

(8) has refused without good cause to participate in the work incentive program under part C, or who refuses without good cause as determined by the Secretary of Labor to accept employment;

(9) within one year immediately preceding his application for aid to families with dependent children transferred property (of any type) to a relative for less than fair market value, if the retention of such property would have caused him to be found to be ineligible for such aid,

and (but only if the State, at its option, so provides in its plan approved under this part) does not include any one or more of the following—

(10) an individual who is absent from such State for a period in excess of 90 consecutive days (regardless of whether he maintains his residence in the State during such period) until he has been present in the State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual;

(11) an individual who will not agree, as a condition of initial or continuing eligibility for such aid, to permit inspection of his home, at reasonable times and with reasonable notice, by any duly authorized person employed by or on behalf of such State in the administration of such plan; or

(12) a child and the relative with whom the child is living if—

(A) such relative is not the child's natural or adoptive parent or legal guardian and would not himself be an eligible person if such child were not living with him, and

(B) the child's natural or adoptive parent is receiving aid pursuant to a State plan approved under this part.

- (g) *The term "family headed by an employable person" means any family which—*
- (1) *includes a father who is not incapacitated;*
 - (2) *includes a mother with no child under six, unless the mother is—*
 - (A) *ill, incapacitated, or of advanced age;*
 - (B) *too remote from an employment program operated pursuant to title XX to be able to participate in such program;*
 - (C) *needed at home to care for an incapacitated family member; or*
 - (D) *attending school on a full-time basis; or*
 - (3) *includes an individual who is participating in the employment program operated pursuant to title XX.*¹

SUBPART 3—PAYMENT TO STATES

SEC. 412. (a) (1) (A) *From the sums appropriated therefor, the Secretary shall, for the calendar year beginning January 1, 1973, pay to each State which has an approved plan for aid to families with dependent children an amount equal to the greater of—*

(i) *an amount equal to 110 per centum of the Federal share (as defined in subparagraph (B)(i)) for such State for quarters in calendar year 1972; or*

(ii) *an amount equal to whichever of the following is the lesser:*

(I) *the Federal share for such State for quarters in calendar year 1972, plus one-half of the State's share (as defined in subparagraph (B)(ii)) for such quarters; or*

(II) *an amount equal to the total expenditures as aid to families with dependent children (as defined in section 406(b), as such section was in effect during quarters in calendar year 1972) which would have been made in such quarters if, for each of such quarters, the State plan had provided (a) for the furnishing of such aid in the form of money payments to families with no other income, of \$66.67 per month (in the case of a family with one member), \$133.33 per month (in the case of a family with two members), \$166.67 per month (in the case of a family with three members), and \$200.00 per month (in the case of a family with four or more members), and (b) for a reduction in the amount of such aid payable to any such family for any month by an amount equal to any other income such family received for such month which would not have been disregarded under section 404(d),*

but such payment shall be made only if the State does not require its political subdivisions to provide financial participation in expenditures for aid under the plan in excess of the difference between such payment and such expenditures. In the case of any State which did not have in effect a State plan approved under title XIX for quarters in calendar year 1972, the amount described in clause (A) may, at the option of such State, be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of

¹ Subsection (g) becomes effective January 1, 1974.

the percentages provided under paragraph (1) or (2) of section 403(a) (as such sections were in effect during calendar year 1972), to the expenditures under its State plan approved under part A of title IV (as such part was in effect during such calendar year) which would be included in determining the amount of the Federal payments to which such State is entitled under such section, but without regard to any maximum on the dollar amounts per recipient which may be counted under such section.

Notwithstanding any other provisions of this section, the Federal payment under this paragraph shall be reduced by an amount equal to any expenditures made under the plan with respect to any dependent child as defined in section 411(a)(1)(A)(i), (I) for any part of the 30-day period referred to in subclause (I) of section 411(a)(2)(B)(i), or (II) for any period prior to the time when the father satisfies subclause (II) of such section, and (ii) if, and for as long as, no action is taken (after the 30-day period referred to in subclause (I) of subparagraph (B)(ii)), under the program therein specified, to certify such father to the Secretary of Labor pursuant to section 409.

(B) As used in this paragraph—

(i) the term "Federal share", with respect to any State, means the amount determined for such State under subsection (a)(1) or (2) of section 403, section 1118, and section 9 of the Act of April 19, 1950, with respect to total expenditures as aid to families with dependent children (as defined in section 406(b)) under the plan of such State approved under this part (as the above referred to sections were in effect during the quarters for which such amount was determined), and

(ii) the term "State share", with respect to any State, means such total expenditures reduced by the Federal share with respect to such State.

(2)(A) From the amounts appropriated therefor, the Secretary shall pay to each State (in addition to the amounts paid to such State under any other provision of this section) for each quarter an amount equal to the total amount by which payments of aid to families with dependent children under the State plan with respect to any family (when increased by the other income of the family taken into account after application of section 404(d)) exceed the adjusted payment level (as defined in subparagraph (B)) of such State, but not counting so much of any such payments when so increased as exceeds the sum of such adjusted payment level plus the bonus value of food stamps (as defined in subparagraph (C)).

(B)(i) As used in this paragraph, the term "adjusted payment level", in the case of any State, means the amount of the money payment which a family of a given size with no other income would have received under the State plan approved under this part for October 1972, increased by a payment level modification.

(ii) As used in this subparagraph, the term "payment level modification", in the case of any State, means that amount by which such State (which for October 1972 made money payments under its plan approved under this part to families with no other income which were less than 100 per centum of its standard of need) could have in-

creased such money payments without increasing (if it reduced its standard of need under such plan so that such increased money payments equaled 100 per centum of such standard of need) the non-Federal share of expenditures for such money payments for October 1972 (as defined in subparagraph (D)).

(C) As used in this paragraph, the term "bonus value of food stamps" means—

(i) the face value of the coupon allotment which would have been provided for October 1972 to a family of a given size under the Food Stamp Act of 1964, reduced by

(ii) the charge which such family would have paid for such coupon allotment,

if the income of such family for such month had been equal to the adjusted payment level. The face value of food stamps and the charge therefor in October 1972 shall be determined in accordance with rules prescribed by the Secretary of Agriculture in effect for such month.

(D) As used in this paragraph the term "non-Federal share of expenditures for money payments for June 1972", in the case of any State, means—

(i) total expenditures by such State for money payments for such month under its State plan approved under this part reduced by

(ii) the amount determined for such State for such month under subsection (a) (1) or (2) of section 403, section 1118, and section 9 of the Act of April 19, 1950 (as such sections were in effect during such month).

(3) In addition to the amounts paid pursuant to paragraphs (1) and (2) the Secretary shall, subject to section 1130, pay to each State an amount equal to the sum of the following proportions of the total amounts expended during each quarter, commencing with the quarter beginning January 1, 1973, as are found necessary by the Secretary for the proper and efficient administration of the plan (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods of administration included in the State plan pursuant to section 402(d)(1))—

(A) 100 per centum of so much of such expenditures as are for family planning services;

(B) 90 per centum of so much of such expenditures as are for services (other than family planning services) which are provided pursuant to section 409(f);

(C) 75 per centum of so much of such expenditures as are for—

(i) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision, and

(ii) emergency assistance provided pursuant to section 410(a)(2);

(D) except as otherwise provided under the preceding subparagraphs, 75 per centum of so much of such expenditures as are for—

(i) any services to families with dependent children which are provided pursuant to section 407 to any child or relative

who is receiving aid under the plan, or to any other individual (living in the same home as such relative and child) whose needs are taken into account in making the determination under section 404(c),

(ii) any such services which are provided to any child or relative who is applying for aid to families with dependent children or who, within such period or periods as the Secretary may by regulation prescribe, has been or is likely to become a recipient of such aid, and

(E) one-half the remainder of such expenditures, including—

(i) expenditures for emergency assistance to families other than families of migrant workers,

(ii) expenditures by the State agency, or the local agency administering the plan in the political subdivision, or a State or local law enforcement agency, in connection with the prosecution of cases involving fraud related to the program operated pursuant to the State plan approved under this part, and

(iii) services provided pursuant to section 406(a)(3)(B).

Payment by the Secretary with respect to expenditures described in subparagraph (E) (ii) by agencies other than the State agency shall be made only to the extent that the State agency reimburses such local agencies by the amount of such payment. The services referred to in subparagraphs (A) and (D) shall include only—

(F) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: Provided, That no funds authorized under this part shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (G), if provided by such staff, and

(G) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in subparagraph (F) (ii) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved; and except that, to the extent specified by the Secretary, services to families with

dependent children may be provided from sources other than those referred to in each of subparagraphs (F) and (G). The portion of the amount expended for administration of the State plan to which each of subparagraphs (A) through (D) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) one-quarter of the amount determined for such State (for the calendar year in which such quarter occurs) under paragraph (1) of such subsection, (B) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the other provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarters, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (C) records showing the number of dependent children in the State, and (D) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary, (A) reduced or increased, as the case may be, by any sum by which the Secretary finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, and (B) adjusted by a sum equivalent to the pro rata share to which the United States or such State is equitably entitled, as determined by the Secretary of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to aid to families with dependent children furnished under the State plan or by the United States; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary, the amount so certified.

[(c) Notwithstanding any other provision of this Act, the Federal share of assistance payments under this part shall be reduced with respect to any State for each of the first two quarters of the fiscal year ending June 30, 1974, by one percentage point for each percentage by which the number of individuals certified, under the program of such State established pursuant to section 409(f), to the local employment office of the State as being ready for employment or training under part C, is less than 15 per centum of the average number of individuals in such State who, during such year, are required to be registered pursuant to section 409(a).] ¹

¹ See footnote 1 on page 834.

→(c) *Notwithstanding subsection (a), the amount payable to any State under this part for quarters in fiscal years beginning after June 30, 1975, shall—*

→(1) *be reduced by 2 per centum (calculated without regard to any reduction under paragraph (2)) of such amount if such State, in the immediately preceding fiscal year, failed to carry out fully the provisions of section 407(a)(3) requiring the offering and provision of family planning services and supplies; or*

→(2) *with respect to quarters in fiscal years beginning after June 30, 1975, be reduced by 2 per centum (calculated without regard to any reduction under paragraph (1)) of such amount if such State, in the immediately preceding fiscal year, fails to—*

→(A) *inform all adults in the State receiving aid to families with dependent children or participating in the employment program operated pursuant to title XX of the availability of child health screening services under the plan of such State approved under title XIX,*

→(B) *provide or arrange for the provision of such services in all cases where they are requested, or*

→(C) *arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.*^{←1}

■(d) *Of the sums authorized by section 401 to be appropriated for the fiscal year ending June 30, 1973, not more than \$750,000,000 shall be appropriated to the Secretary for payments with respect to services to which subsection (a)(3)(B) applies.*■²

→(d) *From the sums appropriated therefor, the Secretary shall pay to each State which has an approved plan for aid to families with dependent children—*

→(1) *for the calendar year beginning January 1, 1974, an amount equal to the amount determined under subsection (a)(1) for such State reduced by that percentage of such amount determined under such subsection which, when increased by 10 percentage points, bears the same ratio to 100 as the average number of families receiving aid under such State plan for months in calendar year 1973 which were headed by a father (including a stepfather) who was not disabled or by a mother with no child under the age of six bears to the average number of all families receiving aid under such State plan for months in such year, and*

→(2) *for calendar years beginning after December 31, 1974, an amount which bears the same ratio to the amount determined for such State under clause (1) as the population of such State in the calendar year for which the determination under this clause (2) is made bears to the population of such State in the calendar year beginning January 1, 1974.*

In order for a State to be eligible for payments under this subsection, any official or agency of such State which makes cash assistance payments based on need under any program of the State shall apply the provisions of section 404(d)(3) in determining eligibility for and the

¹ Effective January 1, 1974, the first subsection 412(c) is deleted and replaced by the next following subsection 412(c) appearing between arrows.

² See footnote 1 on page 835.

amount of such payments in the same manner and to the same extent as provided in the plan of such State approved under this part. ← ¹

(e) Notwithstanding any other provision of this part, the payment which would otherwise be made to a State pursuant to subsection (a) (1) (A) shall be reduced by 1 percentage point for each percentage in excess of 10 per centum by which the average monthly number of individuals (for months in the year for which such payment would be made) with respect to whom protective payments, as defined in section 406 (b), are made exceeds the average monthly number of all individuals (for months in such year) receiving aid under the plan. In computing such 10 per centum, there shall not be taken into account individuals with respect to whom such payments are made for any month in accordance with section 406 (a) (4) or 409 (e).

SUBPART 4—FEDERAL RESPONSIBILITY

Operation of State Plans

SEC. 413. (a) The Secretary shall approve any State plan which meets the requirements of this part.

(b) In the case of any State plan for aid to families with dependent children which has been approved under this part, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by this part to be included in the plan (other than clause (i) of such section 402 to the extent it prohibits the furnishing of aid to persons who have not resided in the State for 90 days), the Secretary shall notify such State agency that further payments shall not be made to the State (or, in his discretion, that payment will be limited to categories under or parts of the State plan not affected for such failure) until the Secretary is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(c) No payment to which a State is otherwise entitled under this title, shall be withheld by reason of any action taken pursuant to a State statute which requires that aid be denied under the State plan approved under this part with respect to a child because of the conditions in the home in which the child resides if provision is otherwise made pursuant to a State statute for adequate care and assistance with respect to such child.

Recovery of Overpayments of Aid to Families With Dependent Children

SEC. 414. In any case in which a State agency has notified the Secretary that it cannot recover from members of a family overpayments of aid to families with dependent children to such family, the Secretary shall recover the amount of such overpayment from any amounts (other than lump-sum death benefits payable under section 202 (i)) otherwise due a member of such family or becoming due such member

¹ Effective January 1, 1974, the first subsection 412 (d) is deleted and replaced by the next following subsection 412 (d) appearing between arrows.

from any officer or agency of the United States or under any Federal program. Any amounts recovered under the preceding sentence shall be credited to the State which made such overpayment.

Part B—Child-Welfare Services

Appropriation

Sec. 420. For the purpose of enabling the United States, through the Secretary, to cooperate with State public welfare agencies in establishing, extending, and strengthening child-welfare services, the following sums are hereby authorized to be appropriated: **[\$55,000,000 for the fiscal year ending June 30, 1968, \$100,000,000 for the fiscal year ending June 30, 1969, and \$110,000,000 for each fiscal year thereafter]** *\$200,000,000 for the fiscal year ending June 30, 1973, \$215,000,000 for the fiscal year ending June 30, 1974, and \$230,000,000 for the fiscal year ending June 30, 1975, \$250,000,000 for the fiscal year ending June 30, 1976, and \$270,000,000 for each fiscal year thereafter.*

Allotments to States

Sec. 421. The sum appropriated pursuant to section 420 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary, as follows: He shall allot \$70,000 to each State, and shall allot to each State an amount which bears the same ratio to the remainder of the sum so appropriated for such year as the product of (1) the population of such State under the age of 21 and (2) the allotment percentage of such State (as determined under section 423) bears to the sum of the corresponding products of all the States.

Payment to States

Sec. 422. (a) From the sums appropriated therefor and the allotment available under this part, the Secretary shall from time to time pay to each State—

(1) that has a plan for child-welfare services which has been developed as provided in this part and which—

(A) provides that (i) the State agency designated pursuant to section 402(a)(3) to administer or supervise the administration of the plan of the State approved under part A of this title will administer or supervise the administration of such plan for child-welfare services and (ii) to the extent that child-welfare services are furnished by the staff of the State agency or local agency administering such plan for child-welfare services, the organizational unit in such State or local agency established pursuant to section 402(a)(15) will be responsible for furnishing such child-welfare services,

(B) provides for coordination between the services provided under such plan and the services provided for dependent children under the State plan approved under part A of this title, with a view to provision of welfare and related services which will best promote the welfare of such children and their families, and

[(C) provides, with respect to day care services (including the provision of such care) provided under this title—

[(i) for cooperative arrangements with the State health authority and the State agency primarily responsible for State supervision of public schools to assure maximum utilization of such agencies in the provision of necessary health services and education for children receiving day care,

[(ii) for an advisory committee, to advise the State public welfare agency on the general policy involved in the provision of day care services under the plan, which shall include among its members representatives of other State agencies concerned with day care or services related thereto and persons representative of professional or civic or other public or nonprofit private agencies, organizations, or groups concerned with the provision of day care,

[(iii) for such safeguards as may be necessary to assure provision of day care under the plan only in cases in which it is in the best interest of the child and the mother and only in cases in which it is determined, under criteria established by the State, that a need for such care exists; and, in cases in which the family is able to pay part or all of the costs of such care, for payment of such fees as may be reasonable in the light of such ability,

[(iv) for giving priority, in determining the existence of need for such day care, to members of low-income or other groups in the population, and to geographical areas, which have the greatest relative need for extension of such day care, and

[(v) that day care provided under the plan will be provided only in facilities (including private homes) which are licensed by the State, or approved (as meeting the standards established for such licensing) by the State agency responsible for licensing facilities of this type, and

[(vi) for the development and implementation of arrangements for the more effective involvement of the parent or parents in the appropriate care of the child and the improvement of the health and development of the child, and]

(2) that makes a satisfactory showing that the State is extending the provision of child-welfare services in the State, with priority being given to communities with the greatest need for such services after giving consideration to their relative financial need, and with a view to making available by July 1, 1975, in all political subdivisions of the State, for all children in need thereof, child-welfare services provided by the staff (which shall to the extent feasible be composed of trained child-welfare personnel) of the State public welfare agency or of the local agency participating in the administration of the plan in the political subdivision,

except that (effective July 1, 1969, or, if earlier, on the date as of which the modification of the State plan to comply with this requirement with respect to subprofessional staff is approved) such plan shall provide for the training and effective use of paid subprofessional staff with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency, an amount equal to the Federal share (as determined under section 423) of the total sum expended under such plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child-welfare services, in developing State services for the encouragement and assistance of adequate methods of community child-welfare organization, in paying the costs of returning any runaway child who has not attained the age of eighteen to his own community in another State, and of maintaining such child until such return (for a period not exceeding fifteen days), in cases in which such costs cannot be met by the parents of such child or by any person, agency, or institution legally responsible for the support of such child. In developing such services for children, the facilities and experience of voluntary agencies shall be utilized in accordance with child-care programs and arrangements in the State and local communities as may be authorized by the State.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of subsection (a).

(2) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

Allotment Percentage and Federal Share

Sec. 423. (a) The "allotment percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 per centum or more than 70 per centum, and (2) the allotment percentage shall be 70 per centum in the case of Puerto Rico, the Virgin Islands, and Guam.

(b) The "Federal share" for any State for any fiscal year shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such States bears to the per capita income of the United States, except that (1) in no case shall the Federal share be less than $33\frac{1}{3}$ per centum or more than $66\frac{2}{3}$ per

centum, and (2) the Federal share shall be $66\frac{2}{3}$ per centum in the case of Puerto Rico, the Virgin Islands, and Guam.

(c) The Federal share and allotment percentage for each State shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Federal shares and allotment percentages promulgated under section 524(c) of the Social Security Act in 1966 shall be effective for purposes of this section for the fiscal years ending June 30, 1968, and June 30, 1969.

(d) For purposes of this section, the term "United States" means the fifty States and the District of Columbia.

Reallotment

Sec. 424. The amount of any allotment to a State under section 421 for any fiscal year which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in such section shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out their State plans so developed for sums in excess of those previously allotted to them under that section and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the State plans so developed, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one, and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under section 421.

Definition

Sec. 425. For purposes of this title, the term "child-welfare services" means public social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent, or neglected children, (3) protecting and promoting the welfare of children of working mothers, and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster family homes [or day-care] or other child-care facilities *other than those defined in section 2118(c)*.

Research, Training, or Demonstration Projects

Sec. 426. (a) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine—

(1) for grants by the Secretary—

(A) to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child-welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare;

(B) to State or local public agencies responsible for administering, or supervising the administration of, the plan under this part, for projects for the demonstration of the utilization of research (including findings resulting therefrom) in the field of child welfare in order to encourage experimental and special types of welfare services; and

(C) to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships with such stipends and allowances as may be permitted by the Secretary; and

(2) for contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research, special projects, or demonstration projects relating to such matters.

(b) Payments of grants or under contracts or cooperative arrangements under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants, contracts, or other arrangements.

National Adoption Information Exchange System

SEC. 427. (a) The Secretary is authorized to provide information, utilizing computers and modern data processing methods, through a national adoption information exchange system to assist in the placement of children awaiting adoption and in the location of children for persons who wish to adopt children, including cooperative efforts with any similar programs operated by or within foreign countries, and such other related activities as would further or facilitate adoptions.

(b) There are authorized to be appropriated \$1,000,000 for the fiscal year ending June 30, 1973, and such sums as may be necessary for succeeding fiscal years, to carry out this section.

【Part C—Work Incentive Program for Recipients of Aid Under State Plan Approved Under Part A

【Purpose

【Sec. 430. The purpose of this part is to require the establishment of a program utilizing all available manpower services, including those authorized under other provisions of law, under which individuals receiving aid to families with dependent children will be furnished incentives, opportunities, and necessary services in order for (1) the employment of such individuals in the regular economy, (2) the training of such individuals for work in the regular economy, and (3) the participation of such individuals in public service employment, thus restoring the families of such individuals to independence and useful roles in their communities. It is expected that the individuals participating in the program established under this part will acquire a sense of dignity, self-worth, and confidence which will flow from being recognized as a wage-earning member of society and that the example of a working adult in these families will have beneficial effects on the children in such families.

【Appropriation

【Sec. 431. (a) There is hereby authorized to be appropriated to the Secretary of Health, Education, and Welfare for each fiscal year a sum sufficient to carry out the purposes of this part. The Secretary of Health, Education, and Welfare shall transfer to the Secretary of Labor from time to time sufficient amounts, out of the moneys appropriated pursuant to this section, to enable him to carry out such purposes.

【(b) Of the amounts expended from funds appropriated pursuant to subsection (a) for any fiscal year (commencing with the fiscal year ending June 30, 1973), not less than 33 $\frac{1}{3}$ per centum thereof shall be expended for carrying out the program of on-the-job training referred to in section 432(b)(1)(B) and for carrying out the program of public service employment referred to in section 432(b)(3).

【(c) Of the sums appropriated pursuant to subsection (a) to carry out the provisions of this part for any fiscal year (commencing with the fiscal year ending June 30, 1973), not less than 50 percent shall be allotted among the States in accordance with a formula under which each State receives (from the total available for such allotment) an amount which bears the same ratio to such total as—

[(1) in the case of the fiscal year ending June 30, 1973, and the fiscal year ending June 30, 1974, the average number of recipients of aid to families with dependent children in such State during the month of January last preceding the commencement of such fiscal year bears to the average number of such recipients during such month in all the States; and

[(2) in the case of the fiscal year ending June 30, 1975, or in the case of any fiscal year thereafter, the average number of individuals in such State who, during the month of January last preceding the commencement of such fiscal year, are registered pursuant to section 402(a) (19) (A) bears to the average number of individuals in all States who, during such month, are so registered.

[Establishment of Programs

[Sec. 432. (a) The Secretary of Labor (hereinafter in this part referred to as the Secretary) shall, in accordance with the provisions of this part, establish work incentive programs (as provided for in subsection (b) in each State and in each political subdivision of a State in which he determines there is a significant number of individuals who have attained age 16 and are receiving aid to families with dependent children. In other political subdivisions, he shall use his best efforts to provide such programs either within such subdivisions or through the provision of transportation for such persons to political subdivisions of the State in which such programs are established.

[(b) Such programs shall include, but shall not be limited to, (1) a program placing as many individuals as is possible in employment, and utilizing on-the-job training positions for others, (2) a program of institutional and work experience training for those individuals for whom such training is likely to lead to regular employment, and (3) a program of public service employment for individuals for whom a job in the regular economy cannot be found.

[(c) In carrying out the purposes of this part the Secretary may make grants to, or enter into agreements with, public or private agencies or organizations (including Indian tribes with respect to Indians on a reservation), except that no such grant or agreement shall be made to or with a private employer for profit or with a private non-profit employer not organized for a public purpose for purposes of the work experience program established by clause (2) of subsection (b).

[(d) In providing the manpower training and employment services and opportunities required by this part, the Secretary of Labor shall, to the maximum extent feasible, assure that such services and opportunities are provided by using all authority available to him under this or any other Act. In order to assure that the services and opportunities so required are provided, the Secretary of Labor shall use the funds appropriated to him under this part to provide programs required by this part through such other Act, to the same extent and under the same conditions (except as regards the Federal matching percentage) as if appropriated under such other Act and, in making

use of the programs of other Federal, State, or local agencies (public or private), the Secretary of Labor may reimburse such agencies for services rendered to persons under this part to the extent such services and opportunities are not otherwise available on a nonreimbursable basis.

[(e) The Secretary shall take appropriate steps to assure that the present level of manpower services available under the authority of other statutes to recipients of aid to families with dependent children is not reduced as a result of programs under this part.

[(f) (1) The Secretary of Labor shall establish in each State, municipality, or other appropriate geographic area with a significant number of persons registered pursuant to section 402(a) (19) (A) a Labor Market Advisory Council the function of which will be to identify and advise the Secretary of the types of jobs available or likely to become available in the area served by the Council; except that if there is already located in any area an appropriate body to perform such function, the Secretary may designate such body as the Labor Market Advisory Council for such area.

[(2) Any such Council shall include representatives of industry, labor, and public service employers from the area to be served by the Council.

[(3) The Secretary shall not conduct, in any area, institutional training under any program established pursuant to subsection (b) of any type which is not related to jobs of the type which are or are likely to become available in such area as determined by the Secretary after taking into account information provided by the Labor Market Advisory Council for such area.

[Operation of Program

[Sec. 433. (a) The Secretary shall provide a program of testing and counseling for all persons certified to him by a State, pursuant to section 402(a) (19) (G), and shall select those persons whom he finds suitable for the programs established by clauses (1) and (2) of section 432(b). Those not so selected shall be deemed suitable for the program established by clause (3) of such section 432(b) unless the Secretary finds that there is good cause for an individual not to participate in such program. The Secretary, in carrying out such program for individuals certified to him under section 402(a) (19) (G), shall accord priority to such individuals in the following order, taking into account employability potential: first, unemployed fathers; second, mothers, whether or not required to register pursuant to section 402(a) (19) (A), who volunteer for participation under a work incentive program; third, other mothers, and pregnant women, registered pursuant to section 402(a) (19) (A), who are under 19 years of age; fourth, dependent children and relatives who have attained age 16 and who are not in school or engaged in work or manpower training; and fifth, all other individuals so certified to him.

[(b) (1) For each State the Secretary shall develop jointly with the administrative unit of such State administering the special program

referred to in section 402(a)(19)(G) a statewide operational plan.

[(2) The statewide operational plan shall prescribe how the work incentive program established by this part will be operated at the local level, and shall indicate (i) for each area within the State the number and type of positions which will be provided for training, for on-the-job training, and for public service employment, (ii) the manner in which information provided by the Labor Market Advisory Council (established pursuant to section 432(f)) for any such area will be utilized in the operation of such program, and (iii) the particular State agency or administrative unit thereof which will be responsible for each of the various activities and functions to be performed under such program. Any such operational plan for any State must be approved by the Secretary, the administrative unit of such State administering the special program referred to in section 402(a)(19)(G), and the regional joint committee (established pursuant to section 439) for the area in which such State is located.

[(3) The Secretary shall develop an employability plan for each suitable person certified to him under section 402(a)(19)(G) which shall describe the education, training, work experience, and orientation which it is determined that such person needs to complete in order to enable him to become self-supporting.

[(c) The Secretary shall make maximum use of services available from other Federal and State agencies and, to the extent not otherwise available on a nonreimbursable basis, he may reimburse such agencies for services rendered to persons under this part.

[(d) To the extent practicable and where necessary, work incentive programs established by this part shall include, in addition to the regular counseling, testing, and referral available through the Federal-State Employment Service System, program orientation, basic education, training in communications and employability skills, work experience, institutional training, on-the-job training, job development, and special job placement and followup services, required to assist participants in securing and retaining employment and securing possibilities for advancement.

[(e)(1) In order to develop public service employment under the program established by section 432(b)(3), the Secretary shall enter into agreements with (A) public agencies, (B) private nonprofit organizations established to serve a public purpose, and (C) Indian tribes with respect to Indians on a reservation, under which individuals deemed suitable for participation in such a program will be provided work which serves a useful public purpose and which would not otherwise be performed by regular employees.

[(2) Such agreements shall provide—

[(A) for the payment by the Secretary to each employer, with respect to public service employment performed by any individual for such employer, of an amount not exceeding 100 percent of the cost of providing such employment to such individual during the first year of such employment, an amount not exceeding 75 percent of the cost of providing such employment to such individual during the second year of such employment, and an amount not exceeding 50 percent of the cost of providing such employment to such individual during the third year of such employment;

[(B) the hourly wage rate and the number of hours per week

individuals will be scheduled to work in public service employment for such employer;

[(C) that the Secretary will have such access to the premises of the employer as he finds necessary to determine whether such employer is carrying out his obligations under the agreement and this part; and

[(D) that the Secretary may terminate any agreement under this subsection at any time.

[(4) No wage rates provided under any agreement entered into under this subsection shall be lower than the applicable minimum wage for the particular work concerned.

[(f) Before entering into a project under section 432(b) (3), the Secretary shall have reasonable assurances that—

[(1) appropriate standards for the health, safety, and other conditions applicable to the performance of work and training on such project are established and will be maintained,

[(2) such project will not result in the displacement of employed workers,

[(3) with respect to such project the conditions of work, training, education, and employment are reasonable in the light of such factors as the type of work, geographical region, and proficiency of the participant,

[(4) appropriate workmen's compensation protection is provided to all participants.

[(g) Where an individual certified to the Secretary of Labor pursuant to section 402(a) (19) (G) refuses without good cause to accept employment or participate in a project under a program established by this part, the Secretary of Labor shall (after providing opportunity for fair hearing) notify the State agency which certified such individual and submit such other information as he may have with respect to such refusal.

[(h) With respect to individuals who are participants in public service employment under the program established by section 432(b) (3), the Secretary shall periodically (but at least once every six months) review the employment record of each such individual while on such special work project and on the basis of such record and such other information as he may acquire determine whether it would be feasible to place such individual in regular employment or on any of the projects under the programs established by section 432(b) (1) and (2).

[Incentive Payment

[Sec. 434. (a) The Secretary is authorized to pay to any participant under a program established by section 432(b) (2) an incentive payment of not more than \$30 per month, payable in such amounts and at such times as the Secretary prescribes.

[(b) The Secretary of Labor is also authorized to pay, to any member of a family participating in manpower training under this part, allowances for transportation and other costs incurred by such member, to the extent such costs are necessary to and directly related to the participation by such member in such training.

【Federal Assistance

【Sec. 435. (a) Federal assistance under this part shall not exceed 90 per centum of the costs of carrying out this part. Non-Federal contributions may be cash or in kind, fairly evaluated, including but not limited to plant, equipment, and services.

【(b) Costs of carrying out this part include costs of training, supervision, materials, administration, incentive payments, transportation, and other items as are authorized by the Secretary, but may not include any reimbursement for time spent by participants in work, training, or other participation in the program.

【Period of Enrollment

【Sec. 436. (a) The program established by section 432(b) (2) shall be designed by the Secretary so that the average period of enrollment under all projects under such program throughout any area of the United States will not exceed one year.

【(b) Services provided under this part may continue to be provided to an individual for such period as the Secretary determines (in accordance with regulations prescribed jointly by him and the Secretary of Health, Education, and Welfare) is necessary to qualify him fully for employment even though his earnings disqualify him from aid under a State plan approved under section 402.

【Relocation of Participants

【Sec. 437. The Secretary may assist participants to relocate their place of residence when he determines such relocation is necessary in order to enable them to become permanently employable and self-supporting. Such assistance shall be given only to participants who concur in their relocation and who will be employed at their place of relocation at wage rates which will meet at least their full need as determined by the State to which they will be relocated. Assistance under this section shall not exceed the reasonable costs of transportation for participants, their dependents, and their household belongings plus such relocation allowance as the Secretary determines to be reasonable.

【Participants Not Federal Employees

【Sec. 438. Participants in programs established by this part shall be deemed not to be Federal employees and shall not be subject to the provisions of laws relating to Federal employment, including those relating to hours of work, rates of compensation, leave, unemployment compensation, and Federal employee benefits.

【Rules and Regulations

【Sec. 439. The Secretary and the Secretary of Health, Education, and Welfare, shall, not later than July 1, 1972 issue regulations to

carry out the purposes of this part. Such regulations shall provide for the establishment, jointly by the Secretary and the Secretary of Health, Education, and Welfare, of (1) a national coordination committee the duty of which shall be to establish uniform reporting and similar requirements for the administration of this part, and (2) a regional coordination committee for each region which shall be responsible for review and approval of statewide operational plans developed pursuant to section 433(b).

[Annual Report

[Sec. 440. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the work incentive programs established by this part.

[Evaluation and Research

[Sec. 441. The Secretary shall (jointly with the Secretary of Health, Education, and Welfare) provide for the continuing evaluation of the work incentive programs established by this part, including their effectiveness in achieving stated goals and their impact on other related programs. He also may conduct research regarding ways to increase the effectiveness of such programs. He may, for this purpose, contract for independent evaluations of and research regarding such programs or individual projects under such programs. For purposes of sections 435 and 443, the costs of carrying out this section shall not be regarded as costs of carrying out work incentive programs established by this part. Nothing in this section shall be construed as authorizing the Secretary to enter into any contract with any organization after June 1, 1970, for the dissemination by such organization of information about programs authorized to be carried on under this part.

[Technical Assistance for Providers of Employment or Training

[Sec. 442. The Secretary is authorized to provide technical assistance to providers of employment or training to enable them to participate in the establishment and operation of programs authorized to be established by section 432(b).

[Collection of State Share

[Sec. 443. If a non-Federal contribution of 10 per centum of the costs of the work incentive programs established by this part is not made in any State (as specified in section 402(a)), the Secretary of Health, Education, and Welfare may withhold any action under section 404 because of the State's failure to comply substantially with a provision required by section 402. If the Secretary of Health, Education, and Welfare does withhold such action, he shall, after reasonable notice and opportunity for hearing to the appropriate State agency or

agencies, withhold any payments to be made to the State under sections 3(a), 403(a), 1003(a), 1403(a), 1603(a), and 1903(a) until the amount so withheld (including any amounts contributed by the State pursuant to the requirement in section 402(a)(19)(C)) equals 10 per centum of the costs of such work incentive programs. Such withholding shall remain in effect until such time as the Secretary has assurances from the State that such 10 per centum will be contributed as required by section 402. Amounts so withheld shall be deemed to have been paid to the State under such sections and shall be paid by the Secretary of Health, Education, and Welfare to the Secretary. Such payment shall be considered a non-Federal contribution for purposes of section 435.

【Agreements With Other Agencies Providing Assistance to Families of Unemployed Parents

【Sec. 444. (a) The Secretary is authorized to enter into an agreement (in accordance with the succeeding provisions of this section) with any qualified State agency (as described in subsection (b)) under which the program established by the preceding sections of this part C will (except as otherwise provided in this section) be applicable to individuals by such State agency in the same manner, to the same extent, and under the same conditions as such program is applicable with respect to individuals to the Secretary by a State agency administering or supervising the administration of a State plan approved by the Secretary of Health, Education, and Welfare under part A of this title.

【(b) A qualified State agency referred to in subsection (a) is a State agency which is charged with the administration of a program—

【(1) the purpose of which is to provide aid or assistance to the families of unemployed parents,

【(2) which is not established pursuant to part A of title IV of the Social Security Act;

【(3) which is financed entirely from funds appropriated by the Congress, and

【(4) none of the financing of which is made available under any program established pursuant to title V of the Economic Opportunity Act.

【(c) (1) Any agreement under this section with a qualified State agency shall provide that such agency will, with respect to all individ-

uals receiving aid or assistance under the program of aid or assistance to families of unemployed parents administered by such agency, comply with the requirements imposed by section 402(a)(19) in the same manner and to the same extent as if (A) such qualified agency were the agency in such State administering or supervising the administration of a State plan approved under part A of this title, and (B) individuals receiving aid or assistance under the program administered by such qualified agency were recipients of aid under a State plan which is so approved.

[(2) Any agreement entered into under this section shall remain in effect for such period as may be specified in the agreement by the Secretary and the qualified State agency, except that, whenever the Secretary determines, after reasonable notice and opportunity for hearing to the qualified State agency, that such agency has failed substantially to comply with its obligations under such agreement, the Secretary may suspend operation of the agreement until such time as he is satisfied that the State agency will no longer fail substantially to comply with its obligations under such agreement.

[(3) Any such agreement shall further provide that the agreement will be inoperative for any calendar quarter if, for the preceding calendar quarter, the maximum amount of benefits payable under the program of aid or assistance to families of unemployed parents administered by the qualified State agency which is a party to such agreement is lower than the maximum amount of benefits payable under such program for the quarter which ended September 30, 1967.

[(d) The Secretary shall, at the request of any qualified State agency referred to in subsection (a) of this section and upon receipt from it of a list of the names of individuals rereferred to the Secretary, furnish to such agency the names of each individual on such list participating in public service employment under section 433(a)(3) whom the Secretary determines should continue to participate in such employment. The Secretary shall not comply with any such request with respect to an individual on such list unless such individual has been certified to the Secretary by such agency under such section 402(a)(19)(G) for a period of at least six months.]

**PART D—CHILD SUPPORT AND ESTABLISHMENT OF
PATERNITY**

Appropriation

SEC. 451. For the purposes of enforcing (1) the support obligations owed by absent parents to children receiving assistance under Part A of this title, (2) the residual monetary obligation owed to the United States by absent parents, and (3) the criminal penalties for nonsupport against absent parents, there is hereby authorized to be appropriated to the Attorney General for each fiscal year a sum sufficient to carry out the purposes of this part.

Duties of Attorney General

SEC. 452. (a) The Attorney General shall enforce the support rights assigned to him under section 402(h) by applicants for and recipients of assistance under part A of this title, utilizing all funds and authority which are available to him for this purpose. To the extent required, he shall locate absent parents, determine paternity in order to establish duty to support, obtain support orders, collect support payments by use of voluntary agreements or other means, and enforce the residual monetary obligation owed the United States and the criminal provisions for nonsupport by such parents.

(b)(1) The Attorney General shall, in accordance with procedures applicable to the recovery of obligations due the United States, including, where appropriate, the use of voluntary agreements, and in accordance with the priorities for distribution specified in section 455, collect and distribute amounts from enforcement of obligations under paragraph (2). Whenever any individual is determined to be liable to the United States for any amount under this section, the Attorney General may make certification of such amount to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954. The Attorney General shall reimburse the Secretary of the Treasury for any costs involved.

(2) The Attorney General is authorized to bring civil action in any court of competent jurisdiction (including the courts in any State or political subdivision thereof) against an absent parent to secure (A) support obligations assigned to him under section 402(h), and (B) the residual monetary obligation owed to the United States as defined in section 457, except that all or part of such obligation may be suspended or forgiven by the Attorney General upon a finding of good cause. In taking actions against an absent parent, the Attorney General shall give priority to obtaining orders and proceeding with collections required under subsection (b)(2)(A).

(3) *The Attorney General may enter into voluntary agreements to recover support obligations assigned under section 402(h), if there is no court order in effect directing payment of such obligation or if there is such an order in effect but there is no reasonable expectation that it can be enforced or that the obligation can be collected. Any voluntary agreement so made shall provide that support payments will not cease if the family ceases to receive assistance under part A of this title, and the amounts payable under such agreement, if there is no court order in effect, may be collected as authorized under the provisions of this part.*

(c) *The Attorney General and the Director of the Office of Economic Opportunity are directed to enter into an appropriate arrangement under which the services of attorneys participating in legal services programs established pursuant to section 222(a)(3) of the Economic Opportunity Act of 1964 will be made available to the Attorney General to assist him in carrying out his functions under this part. The Attorney General shall, to the maximum extent feasible, utilize the services of such attorneys in the performance of such functions and may make the services of such attorneys available to States or political subdivisions to assist them in carrying out the purposes of this part. The Office of Economic Opportunity shall be reimbursed by the Attorney General for the costs incurred in providing such services.*

(d) *The Attorney General shall require that each United States attorney designate an assistant United States attorney to be responsible for enforcement of the provisions of this part in his judicial district and maintain liaison with and assist the States and political subdivisions thereof in their child support efforts. Each assistant United States attorney so designated shall prepare and submit to the Attorney General for submission to the Congress quarterly reports on all activities undertaken pursuant to this section.*

(e) (1) *There is hereby established in the Treasury a revolving fund to be known as the Federal Child Support Fund (hereinafter referred to as the "fund" which shall be available to the Attorney General without fiscal year limitation, to enable him to carry out his responsibilities under this part.*

(2) *Except as provided in sections 454(d) and 458, all moneys appropriated pursuant to section 451 for the purpose of funding Federal activities under this part and all moneys collected by the Federal Government pursuant to this part (including support payments and payments by way of reimbursement received from Federal agencies, States and political subdivisions thereof, and individuals) shall be paid into the fund and shall be disbursed by the Attorney General from time to time in accordance with the provisions of this part.*

(3) *There is hereby appropriated to the fund, out of any moneys in the Treasury not otherwise appropriated, amounts equal to the amounts collected under section 6305 of the Internal Revenue Code of 1954, reduced by the amounts credited or refunded as overpayments of the amounts so collected. The amounts appropriated by the preceding sentence shall be transferred at least quarterly from the general fund of the Treasury to the fund on the basis of estimates made by the Secretary of the Treasury. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates*

were in excess of or less than the amounts required to be transferred.

(f) The Attorney General shall notify the Secretary of the failure of the State agency administering the plan approved under part A of this title to provide prompt notice (including the transmittal of all relevant information) of the furnishing of aid to families with dependent children with respect to a child who has been deserted or abandoned by a parent as required under section 402(f).

(g) The Attorney General shall maintain complete records of all amounts collected under this part and of the costs incurred in collecting such amounts and shall, not later than June 30 of each year (commencing with June 30, 1974), submit to the Congress a written report on all activities undertaken pursuant to the provisions of this part.

Parent Locator Service

Sec. 453. (a) The Attorney General shall establish and conduct, within the Department of Justice, a Parent Locator Service which shall be used to obtain and transmit to any authorized person (as defined in subsection (c)) information as to the whereabouts of any absent parent when such information is to be used to locate such parent for the purpose of enforcing support obligations against such parent.

(b) Upon request, filed in accordance with subsection (d) of any authorized person (as defined in subsection (c)) for the most recent address and place of employment of any individual, the Attorney General shall, notwithstanding any other provision of law, provide through the Parent Locator Service such information to such person, if such information—

(1) is contained in any files or records maintained by the Attorney General or by the Department of Justice; or

(2) is not contained in such files or records, but can be obtained by the Attorney General, under the authority conferred by subsection (e), from any other department, agency, or instrumentality, or the United States or of any State.

The Attorney General shall give priority to requests made by any authorized person described in subsection (c) (1).

(c) As used in subsection (a), the term "authorized person" means—

(1) any agent or attorney of the United States or of any State or any political subdivision to which support collection functions have been delegated under section 454, who has the duty or authority to seek to recover any amounts under section 452;

(2) the court which has authority to issue an order against an absent parent for the support and maintenance of a child, or any agent of such court; and

(3) the parent, guardian, attorney, or agent of a child (other than a child receiving aid under part (A) without regard to the existence of a court order against an absent parent who has a duty to support and maintain any such child.

(d) A request for information under this section shall be filed in such manner and form as the Attorney General shall by regulation prescribe and shall be accompanied or supported by such documents as the Attorney General may determine to be necessary.

(e) (1) Whenever the Attorney General receives a request submitted under subsection (b) which he is reasonably satisfied meets the cri-

teria established by subsections (a), (b), and (c), he shall promptly undertake to provide the information requested from the files and records maintained by any of the departments, agencies, or instrumentalities of the United States or of any State.

(2) Notwithstanding any other provision of law, whenever the individual who is the head of any department, agency, or instrumentality of the United States receives a request from the Attorney General for information authorized to be provided by the Attorney General under this section, such individual shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality with a view to determining whether the information requested is contained in any such files or records. If such search discloses the information requested, such individual shall immediately transmit such information to the Attorney General; and, if such search fails to disclose the information requested, such individual shall immediately so notify the Attorney General. The costs incurred by any such department, agency, or instrumentality of the United States or of any State in providing such information to the Attorney General shall be reimbursed by him. Whenever such services are furnished to an individual specified in subsection (c) (3), a fee shall be charged such individual. The fee so charged shall be deposited in the fund and shall be used to reimburse the Attorney General or his delegate for the expense of providing such services.

(f) The Attorney General, in carrying out his duties and functions under this section, shall enter into arrangements with State agencies administering or supervising the administration of State plans approved under part A of this title, under which the offices operated under such plans will accept from parents, guardians, or agents of a child described in subsection (c) (3) and transmit to the Attorney General requests for information with regard to the whereabouts of absent parents and will otherwise cooperate with the Attorney General in carrying out the purposes of this section.

Delegation of Support Collection Functions to States or Political Subdivisions

SEC. 454. (a) The Attorney General shall delegate to any State having a plan approved under part A of this title the authority to recover the child support obligation assigned to the United States under section 402 (h) if he determines that such State has an effective program (in accordance with the standards established in subsection (b)) for locating absent parents, determining paternity, obtaining support orders, and collecting amounts of money owed by parents for the support and maintenance of their child or children. Such a delegation may be made to a political subdivision of any such State upon a finding that the State as a whole does not have an effective program for locating absent parents, determining paternity, obtaining support orders, and collecting child support but that such political subdivision does have an effective program which meets the standards established in subsection (b).

(b) The Attorney General shall not approve any program pursuant to subsection (a) unless such program provides—

(1) for the development and implementation of a program under which such State or political subdivision will undertake—

(A) in the case of a child born out of wedlock with respect to whom an assignment under section 402(h) of this title is effective, to establish the paternity of such child, and

(B) in the case of any child with respect to whom such assignment is effective, to secure support for such child from his parent (or from any other person legally liable for such support), utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support, and

(2) for the establishment of an organizational unit in the State or political subdivision administering the program under this section;

(3) for entering into cooperative arrangements with appropriate courts and law enforcement officials (A) to assist the State or political subdivision administering the program under this section, including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the State or political subdivision administering the program under this section;

(4) that the State or political subdivision will establish a service to locate absent parents utilizing—

(A) all sources of information and available records; and

(B) the Parent Locator Service in the Department of Justice;

(5) that the State or political subdivision will, in accordance with standards prescribed by the Attorney General, cooperate with the State or political subdivision of another State or with the Attorney General in administering a program under this part—

(A) in establishing paternity, if necessary,

(B) in locating an absent parent residing in the State (whether or not permanently) against whom any action is being taken under this part in another State,

(C) in securing compliance by an absent parent residing in such State (whether or not permanently) with a voluntary agreement or an order issued by a court of competent jurisdiction against such parent for the support and maintenance of a child or children of such parent with respect to whom aid is being provided under the plan of such other States, and

(D) in carrying out other functions required by this part;

(6) that the State or political subdivision may enter into voluntary agreements to recover child support obligations delegated under subsection (a), if there is no court order in effect directing payment of such obligation or if there is such an order in effect but there is no reasonable expectation that it can be enforced or that the obligation can be collected. Any voluntary agreement so made shall provide that support payments will not cease if the family ceases to receive assistance under part A of this title, and the amounts payable under such agreement, if there is no court order in effect, may be collected as authorized under the provisions of this part;

(7) that the State or political subdivision require, as a condition of the absent parent being permitted to make support pay-

ments on a voluntary basis, the execution by such parent of an appropriate affidavit (which shall be recorded in the records of the court or other appropriate agency) in which such parent acknowledges the paternity of such child or children;

(8) that, if the State uses voluntary agreements under paragraph (6), it will establish an administrative mechanism for enforcing such agreements;

(9) that such State or political subdivision will comply with such other requirements as the Attorney General determines to be necessary to the establishment of an effective program for locating absent parents, determining paternity, obtaining support orders, and collecting support payments including, but not limited to, requiring a full record of collections and disbursements; and

(10) that the State or political subdivision shall reimburse the Attorney General for the costs incurred by the Federal Government in enforcing and collecting support obligations assigned under this section.

(c) The Attorney General shall, upon the request of any State or political subdivision to which he has delegated the authority to recover the child support obligation assigned to the United States under section 402(h), make available to such State or political subdivision (1) the services of attorneys participating in legal services programs who are, by reason of the agreement required by section 452(c), assisting the Attorney General in carrying out his functions under this part, and (2) upon a showing by the State or political subdivision that such State or political subdivision made diligent and reasonable efforts in utilizing their own collection mechanisms, the collection facilities of the Department of the Treasury (subject to the same requirements of certification by the Attorney General imposed by section 452(b) and subject to such limitations on the frequency of making such certification as may be imposed by the Attorney General).

(d) From the sums appropriated therefor, the Attorney General shall pay to each State or political subdivision which has a program approved under this section, for each quarter, beginning with the quarter commencing January 1, 1973, an amount equal to 75 percent of the total amounts expended by such State or political subdivision during such quarter for the operation of the program approved under this section except as provided in sections 455(b)(2), 456, and 459.

Distribution of Proceeds From Support Collections

Sec. 455. (a) Amounts collected as support obligations assigned under section 402(h) shall be distributed in the following order of priority—

(1) If a State or its agent makes the collection, the proceeds of such collection shall be distributed, beginning with the first dollar, as follows—

(A) the family shall be paid—

(i) 100 percent of such proceeds if they are equal to or less than the amount of the assistance payment which would otherwise be made, or

(ii) an amount of such proceeds that is equal to the lesser of (1) the amount required by a court order to be

paid for child support or (II) the amount agreed upon by the parties to a voluntary child support agreement, and any proceeds so paid that are in excess of the amount of the assistance payment otherwise payable shall be deemed to reduce the residual monetary obligation to the Federal Government by a like amount;

(B) such amounts as may be necessary to reimburse the State for such State's share of assistance payments (with appropriate reimbursement of the political subdivision if it participated in the financing) made to the family prior to the date on which the support obligation was collected shall be paid to such State, and any amounts so paid shall be deemed to reduce the residual monetary obligation to the Federal Government by a like amount; and

(C) such amounts as may be necessary to reduce or eliminate the residual monetary obligation to the Federal Government by the absent parent shall be paid to the Federal Government and deposited in the fund.

(2) If a political subdivision or its agent makes the collection, the proceeds of such collection shall be distributed, beginning with the first dollar, as follows—

(A) the family shall be paid—

(i) 100 percent of such proceeds if they are equal to or less than the amount of the assistance payment which would otherwise be made, or

(ii) an amount of such proceeds that is equal to the lesser of (I) the amount required by a court order to be paid for child support or (II) the amount agreed upon by the parties to a voluntary child support agreement,

and any proceeds so paid that are in excess of the amount of the assistance payment otherwise payable shall be deemed to reduce the residual monetary obligation to the Federal Government by a like amount;

(B) such amounts as may be necessary to reimburse the political subdivision for its share of assistance payments made to the family prior to the date on which the support obligation was collected shall be paid to such political subdivision, and any amounts so paid shall be deemed to reduce the residual monetary obligation to the Federal Government by a like amount; and

(C) such amounts as may be necessary to reduce or eliminate the residual monetary obligation to the Federal Government by the absent parent shall be paid to the Federal Government and deposited in the fund.

(3) If the Attorney General makes the collection, the proceeds of such collection shall be distributed, beginning with the first dollar, as follows—

(A) the family shall be paid—

(i) 100 percent of such proceeds if they are equal to or less than the amount of the assistance payment which would otherwise be made, or

(ii) an amount of such proceeds that is equal to the lesser of (I) the amount required by a court order to be paid for

child support or (II) the amount agreed upon by the parties to a voluntary child support agreement, and any proceeds so paid that are in excess of the amount of the assistance payment otherwise payable shall be deemed to reduce the residual monetary obligation to the Federal Government by a like amount; and

(B) such amounts as may be necessary to reduce or eliminate the residual monetary obligation to the Federal Government by the absent parent shall be paid to the Federal Government and deposited in the fund.

Whenever payments are made pursuant to paragraph (2) (A) or (3) (A) to a family residing in a State which does not have an approved support program under this part, the Attorney General shall so certify to the Secretary, who shall reduce the amount of any grant made to such State under part A of this title by an amount equal to the amount so certified and deposit such amount into the fund, except that such reduction shall not be greater than the amount of the assistance payment such family would have received from such State had the payment under paragraph (2) (A) or (3) (A) not been made.

(b) Whenever a family for whom support payments have been collected and distributed under this part ceases to receive assistance under part A of this title, the Attorney General, or the State or political subdivision to which the Attorney General has delegated the authority to collect support obligations pursuant to this part, shall—

(1) continue to collect such support payments from the absent parent for a period of three months from the month following the month in which such family ceased to receive assistance under part A of this title, and pay all amounts so collected to the family; and

(2) at the end of such three-month period, if the Attorney General (A) is authorized to do so by the individual on whose behalf the collection will be made and (B) finds that the absent parent has not met his support obligation for the period of twenty-four consecutive months immediately preceding the end of such three-month period or throughout the term of such obligation, whichever is shorter, continue to collect such support payments from the absent parent until he has met his support obligation for a period of twenty-four consecutive months, and pay the net amount of any amount so collected to the family after deducting any costs incurred in making the collection from the amount of any recovery made.

Incentive Payment to Localities

SEC. 456. When a political subdivision of a State makes the enforcement and collection of the support obligation assigned under section 402(h) (either within or outside of such State, and whether as the agent of such State or as the agent of the Attorney General), an amount equal to 25 percent of any amount collected and required to be distributed as provided in sections 455(a)(1) (A) and (B), or in sections 455(a)(2) (A) and (B), as appropriate, to reduce or eliminate assistance payments, shall be paid to such political subdivision by the State from amounts which the State would otherwise pay as assist-

ance to the family of the absent parent under section 454(a)(1), or by the Attorney General (when he, or a political subdivision acting as his delegate, makes the collection) from the amounts required to be deducted, by the last sentence of section 455(a), from the grant made to such State.

Residual Monetary Obligation to the United States

Sec. 457. *There is hereby imposed on any absent parent whose child or children have received assistance payments under part A of this title a residual monetary obligation to the United States. Such obligation shall be in an amount that is equal to the total amounts of payments made to the family of an absent parent each month under the State plan approved under part A of this title, or, if less, 50 percent of the monthly income of the absent parent for each such month (but not less than \$50 per month), except that during any month in which an absent parent is meeting his support obligations by paying the full amount of a court ordered support payment or the full amount of the support payment which he has agreed to pay according to the terms of a voluntary support agreement entered into between him and the Attorney General (or his delegate), whichever is larger, no obligation shall be imposed. Interest on any such amount shall accrue at the rate of 6 percent per annum, but the total amount of such obligation (including interest thereon) shall be reduced by the amount of any sums collected by a State or political subdivision which represent such State or political subdivision's share of assistance payments made under the State plan approved under part A of this title.*

Regional Laboratories to Establish Paternity Through Analysis and Classification of Blood

Sec. 458. (a) *The Secretary shall establish, or arrange for the establishment or designation, in each region of the United States, a laboratory which he determines to be qualified to provide services in analyzing and classifying blood for the purpose of determining paternity, and which is prepared to provide such services to courts and public agencies in the region to be served by it.*

(b) *Whenever a laboratory is established or designated for any region by the Secretary under this section, he shall take such measures as may be appropriate to notify appropriate courts and public agencies (including agencies administering any public welfare program within such region) that such laboratory has been so established or designated to provide services, in analyzing and classifying blood for the purpose of determining paternity, for court and public agencies in such region.*

(c) *The facilities of any such laboratory shall be made available without cost to courts and public agencies in the region to be served by it.*

(d) *There is hereby authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this section.*

Collection of Child Support for Participants in Guaranteed Employment

Sec. 459. Any individual who is participating in guaranteed employment under subpart 1 of part B of title XX of this Act shall be eligible to receive the child support collection or paternity determination services established under this part. Such services shall be made available to any such individual upon application filed while such individual is participating in guaranteed employment (in accordance with such procedures and containing such information as the Attorney General shall by regulation prescribe) with the Attorney General or, if a State or political subdivision has a program approved under section 455, with such State or political subdivision, as may be appropriate. Any costs incurred by the Attorney General (or by a State or political subdivision) in furnishing such services shall be paid by such individual by deducting such costs from the amount of any recovery made.

Consent by the United States to Garnishment and Similar Proceedings for Enforcement of Child Support and Alimony Obligations

Sec. 460. Notwithstanding any other provision of law, moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, the United States (including any agency or instrumentality thereof and any wholly owned Federal corporation) to any individual, including members of the armed services, shall be subject, in like manner and to the same extent as if the United States were a private person, to legal process brought for the enforcement, against such individual, of his legal obligations to provide child support or make alimony payments.

Penalty for Nonsupport

Sec. 461. (a) Any individual who is the parent of any child or children and who is under a legal duty to provide for the support and maintenance of such child or children (as required under the law of the State where such child or children reside) but fails to perform such duty and has left, deserted, or abandoned such child or children and such child or children receive assistance payments to provide for their support and maintenance which are funded in whole or in part from funds appropriated therefor by the Federal Government shall, upon conviction, be penalized in an amount equal to 50 percent of the residual monetary obligation owed to the United States, or fined not more than \$1,000, or imprisoned for not more than one year, or any combination of these three penalties.

(b) This section does not preempt any State law imposing a civil or criminal penalty on an absent parent for failing to provide support and maintenance to his child or children to whom such parent owes a duty to support.

**PART E—GRANTS TO STATES FOR ESTABLISHMENT OF
MODEL DAY CARE**

Appropriation

Sec. 471. There are authorized to be appropriated for grants to States for development of model day care for children such sums as may be necessary during each of the fiscal years ending on June 30, 1973, June 30, 1974, and June 30, 1975. From the sums authorized to be appropriated pursuant to this section, the Secretary is authorized to approve grants to each State during such fiscal years in amounts up to \$400,000 per year to pay all or part of the cost of developing model child care through the establishment and operation of a child care center or system and to provide training for individuals in the field of child care. Payments under this section may be in advance or by way of reimbursement.

**TITLE V—MATERNAL AND CHILD HEALTH AND
CRIPPLED CHILDREN'S SERVICES**

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Authorization of Appropriations

Sec. 501. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State,

(1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and

(2) services for locating, and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling,

there are authorized to be appropriated \$250,000,000 for the fiscal year ending June 30, 1969, \$275,000,000 for the fiscal year ending June 30, 1970, \$300,000,000 for the fiscal year ending June 30, 1971, \$325,000,000 for the fiscal year ending June 30, 1972, and \$350,000,000 for the fiscal year ending June 30, 1973, and each fiscal year thereafter.

Purposes for Which Funds Are Available

Sec. 502. Appropriations pursuant to section 501 shall be available for the following purposes in the following proportions:

(1) In the case of the fiscal year ending June 30, 1969, and each of the next [4] 5 fiscal years, (A) 50 percent of the appropriation for such year shall be for allotments pursuant to sections 503 and 504; (B) 40 percent thereof shall be for grants pursuant to sections 508, 509, and 510; and (C) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

(2) In the case of the fiscal year ending June 30, [1974] 1975 and each fiscal year thereafter, (A) 90 percent of the appropriation for such years shall be for allotments pursuant to sections 503 and 504; and (B) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

Not to exceed 5 percent of the appropriation for any fiscal year under this section shall be transferred, at the request of the Secretary, from one of the purposes specified in paragraph (1) or (2) to another purpose or purposes so specified. For each fiscal year, the Secretary shall determine the portion of the appropriation, within the percentage determined above to be available for sections 503 and 504, which shall be available for allotment pursuant to section 503 and the portion thereof which shall be available for allotment pursuant to section 504. Notwithstanding the preceding provisions of this section, of the amount appropriated for any fiscal year pursuant to section 501, not less than 6 percent of the amount appropriated shall be available for family planning services from allotments under section 503 and for family planning services under projects under sections 508 and 512.

Allotments to States for Maternal and Child Health Services

Sec. 503. The amount determined to be available pursuant to section 502 for allotments under this section shall be allotted for payments for maternal and child health services as follows:

(1) One-half of such amount shall be allotted by allotting to each State \$70,000 plus such part of the remainder of such one-half as he finds that the number of live births in such State bore to the total number of live births in the United States in the latest calendar year for which he has statistics.

(2) The remaining one-half of such amount shall (in addition to the allotments under paragraph (1)) be allotted to the States from time to time according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary after taking into consideration the number of live births in such State; except that not more than 25 percent of such one-half shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of maternal and child health.

Allotments to States for Crippled Children's Services

Sec. 504. The amount determined to be available pursuant to section 502 for allotments under this section shall be allotted for payments for crippled children's services as follows:

(1) One-half of such amount shall be allotted by allotting to each State \$70,000 and allotting the remainder of such one-half according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in paragraph (2) of section 501 and the cost of furnishing such services to them.

(2) The remaining one-half of such amount shall (in addition to the allotments under paragraph (1)) be allotted to the States from time to time according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary after taking into consideration the number of crippled children in each State in need of the services referred to in paragraph (2) of section 501 and the cost of furnishing such services to them; except that not more than 25 percent of such one-half shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of services for crippled children.

Approval of State Plans

Sec. 505. (a) In order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

(1) provides for financial participation by the State;

(2) provides for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; except that in the case of those States which on July 1, 1967, provided for administration (or supervision thereof) of the State plan approved under section 513 (as in effect on such date) by a State agency other than the State health agency, the plan of such State may be approved under this section if it would meet the requirements of this subsection except for provision of administration (or supervision thereof) by such other agency for the portion of the plan relating to services for crippled children, and, in each such case, the portion of such plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title;

(3) provides (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan and (B) provides for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency;

(4) provides that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(5) provides for cooperation with medical, health, nursing, educational, and welfare groups and organizations and, with respect to the portion of the plan relating to services for crippled children, with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children;

(6) provides for payment of the reasonable cost (as determined in accordance with standards, *consistent with section 1122*, approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

(7) provides, with respect to the portion of the plan relating to services for crippled children, for early identification of children in need of health care and services, and for health care and treatment needed to correct or ameliorate defects or chronic conditions discovered thereby, through provision of such periodic screening and diagnostic services, and such treatment, care and other measures to correct or ameliorate defects or chronic conditions, as may be provided in regulations of the Secretary;

(8) effective July 1, [1973] 1974 provides a program (carried out directly or through grants or contracts) of projects described in section 508 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily helping to reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with child bearing and of satisfactorily helping to reduce infant and maternal mortality;

(9) effective July 1, [1973] 1974 provides a program (carried out directly or through grants or contracts) of projects described in section 509 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the health of children and youth of school or pre-school age;

(10) effective July 1, [1973] 1974 provides a program (carried out directly or through grants or contracts) of projects described in section 510 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the dental health of children and youth of school or preschool age;

(11) provides for carrying out the purposes specified in section 501;

(12) provides for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need;

(13) provides that, where payment is authorized under the plan for services which an optometrist is licensed to perform, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from an optometrist licensed to perform such services except where such services are rendered in a clinic, or another appropriate institution, which does not have an arrangement with optometrists so licensed; [and]

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the indi-

vidual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan **[.1]**; and

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title.

(b) The Secretary shall approve any plan which meets the requirements of subsection (a).

Payments

Sec. 506. (a) From the sums appropriated therefor and the allotments available under section 503(1) or 504(1), as the case may be, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing July 1, 1968, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan with respect to maternal and child health services and services for crippled children, respectively.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c) The Secretary shall also from time to time make payments to the States from their respective allotments pursuant to section 503(2) or 504(2). Payments of grants under sections 503(2), 504(2), 508, 509, 510, and 511, and of grants, contracts, or other arrangements under section 512, may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the section involved.

(d) The total amount determined under subsections (a) and (b) and the first sentence of subsection (c) for any fiscal year ending after June 30, 1968, shall be reduced by the amount by which the sum expended (as determined by the Secretary) from non-Federal sources for maternal and child health services and services for crippled children for such year is less than the sum expended from such sources for such services for the fiscal year ending June 30, 1968. In the case of any such reduction, the Secretary shall determine the portion thereof which shall be applied, and the manner of applying such reduction, to the amounts otherwise payable from allotments under section 503 or section 504.

(e) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder from the allotments under section 503 or section 504 for any period after June 30, 1968, unless the State makes a satisfactory showing that it is extending the provisions of services, including services for dental care for children and family planning for mothers, to which such State's plan applies in the State with a view to making such services available by July 1, 1975, to children and mothers in all parts of the State.

(f) *Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—*

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds in amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or¹

¹ Applies with respect to services furnished by hospitals in accounting periods beginning after December 31, 1972.

(4) *with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirement imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph in any State if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).*

(g) *For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.*

Operation of State Plans

Sec. 507. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 505; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Special Project Grants for Maternity and Infant Care

Sec. 508. (a) In order to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality, the Secretary is authorized to make, from the sums available under clause (B) of paragraph (1) of section 502, grants to the State health agency of any State and, with the consent of such agency, to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75 percent of the cost (exclusive of general agency overhead) of any project for the provision of—

(1) necessary health care to prospective mothers (including, after childbirth, health care to mothers and their infants) who have or are likely to have conditions associated with childbearing or are in circumstances which increase the hazards to the health of the mothers or their infants (including those which may cause physical or mental defects in the infants), or

(2) necessary health care to infants during their first year of life who have any condition or are in circumstances which increase the hazards to their health, or

(3) family planning services, but only if the State or local agency determines that the recipient will not otherwise receive such necessary health care or services because he is from a low-income family or for other reasons beyond his control. Acceptance of family planning services provided under a project under this section (and section 512) shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to the eligibility for or the receipt of any service under such project.

(b) No grant may be made under this section for any project for any period after June 30, [1973] 1974.

Special Project Grants for Health of School and Preschool Children

Sec. 509. (a) In order to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, the Secretary is authorized to make, from the sums available under clause (B) of paragraph (1) of section 502, grants to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 505, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). No project shall be eligible for a grant under this section unless it provides (1) for the coordination of health care and services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare, and education programs for such children, (2) for payment of (A) the reasonable cost (as determined in accordance with standards, *consistent with section 1122*, approved by the Secretary) of inpatient hospital services provided under the project, or (B) if less, the customary charges with respect to such services provided under the project, or (C) if such services are furnished under the project by a public institution free of charge or at nominal charges to the public, an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such institution for such services,¹ and (3) that any treatment, correction of defects, or after-care provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and no such project for children and youth of school age shall be considered to be of a comprehensive nature for purposes of this section unless it includes

¹¹⁰ Applies with respect to services furnished by hospitals in accounting periods beginning after December 31, 1972.

(subject to the limitation in the preceding provisions of this sentence) at least such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

(b) No grant may be made under this section for any project for any period after June 30, **[1973]** 1974.

Special Project Grants for Dental Health of Children

Sec. 510. (a) In order to promote the dental health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, the Secretary is authorized to make grants, from the sums available under clause (B) of paragraph (1) of section 502, to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for dental care and services for children and youth of school age or for preschool children. No project shall be eligible for a grant under this section unless it provides that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control, and unless it includes (subject to the limitation of the foregoing provisions of this sentence) at least such preventive services, treatment, correction of defects, and aftercare, for such age groups, as may be provided in regulations of the Secretary. Such projects may also include research looking toward the development of new methods of diagnosis or treatment, or demonstration of the utilization of dental personnel with various levels of training.

(b) No grant may be made under this section for any project for any period after June 30, **[1973]** 1974.

Training of Personnel

Sec. 511. From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps. In making such grants the Secretary shall give special attention to programs providing training at the undergraduate level.

Research Projects Relating to Maternal and Child Health Services and Crippled Children's Services

Sec. 512. From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to or jointly financed cooperative arrangements with public or other nonprofit institutions of higher learning, and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or crippled children's pro-

grams, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof. Effective with respect to grants made and arrangements entered into after June 30, 1968, (1) special emphasis shall be accorded to projects which will help in studying the need for, and the feasibility, costs, and effectiveness of, comprehensive health care programs in which maximum use is made of health personnel with varying levels of training, and in studying methods of training for such programs, and (2) grants under this section may also include funds for the training of health personnel for work in such projects.

Administration

Sec. 513. (a) The Secretary of Health, Education, and Welfare shall make such studies and investigations as will promote the efficient administration of this title.

(b) Such portion of the appropriations for grants under section 501 as the Secretary may determine, but not exceeding one-half of 1 percent thereof, shall be available for evaluation by the Secretary (directly or by grants or contracts) of the programs for which such appropriations are made and, in the case of allotments from any such appropriation, the amount available for allotments shall be reduced accordingly.

(c) Any agency, institution, or organization shall, if and to the extent prescribed by the Secretary, as a condition to receipt of grants under this title, cooperate with the State agency administering or supervising the administration of the State plan approved under title XIX in the provision of care and services, available under a plan or project under this title, for children eligible therefor under such plan approved under title XIX.

Definition

Sec. 514. For purposes of this title, a crippled child is an individual under the age of 21 who has an organic disease, defect, or condition which may hinder the achievement of normal growth and development.

Observance of Religious Beliefs

Sec. 515. Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

[(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

[(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.]

* * * * *

**TITLE VI—GRANTS TO STATES FOR SERVICES TO THE
AGED, BLIND, OR DISABLED**

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Appropriation

Section 601. *For the purpose of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help needy individuals who are 65 years of age or over, are blind, or are disabled to attain or retain capability for self-support or self-care, there is hereby authorized to be appropriated for each fiscal year, subject to Section 1130, a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for services to the aged, blind, or disabled.*

State Plans for Services to the Aged, Blind, or Disabled

Sec. 602. *(a) State plan for services to the aged, blind, or disabled, disabled, must—*

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

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services under the plan and in assisting any advisory committees established by the State agency;

(5) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(6) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(7) provide, if the plan includes services to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(8) provide a description of the services which the State agency makes available under the plan, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(9) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(10) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of services under the plan;

(11) if the State plan includes services to individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for persons receiving services under the State plan who are 65 years of age or older and who would otherwise need care in such institutions; for services referred to in section 603(a) (1) (A) (i) and (ii) which are appropriate for such persons receiving services and for such patients; and for methods of adminis-

tration necessary to assure that the responsibilities of the State agency under the State plan with respect to such persons receiving services and such patients will be effectively carried out;

(12) if the State plan includes services to individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases.

Notwithstanding paragraph (3), if on October 1, 1972, the State agency which administered or supervised the administration of the plan of such State approved under title X (or so much of the plan of such State approved under title XVI as applies to the blind) was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV (or so much of the plan of such State approved under title XVI as applies to the aged and disabled), the State agency which administered or supervised the administration of such plan approved under title X (or so much of the plan of such State approved under title XVI as applies to the blind) may be designated to administer or supervise the administration of the portion of the State plan for services to the aged, blind, or disabled which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for services under the plan—

- (1) an age requirement of more than sixty-five years; or*
- (2) any residence requirement which excludes any individual who resides in the State; or*
- (3) any citizenship requirement which excludes any citizen of the United States.*

Payments to States

Sec. 603. *(a) From the sums appropriated therefor, the Secretary shall, subject to section 1130, pay to each State which has a plan approved under this title, for each quarter—*

- (1) in the case of any State whose State plan approved under section 602 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—*

(A) 75 per centum of so much of such expenditures as are for—

(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of supplementary security income benefits under title XVI to help them attain or retain capability for self-support or self-care, or

(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of supplementary security income benefits under title XVI, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of supplementary security income benefits under title XVI, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such benefits; plus

(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: Provided, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

(E) under conditions which shall be prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and

which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

(2) in the case of any State whose State plan approved under section 602 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (1) and provided in accordance with the provisions of such paragraph.

(b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c) (1) In order for a State to qualify for payments under paragraph (1) of subsection (a), its State plan approved under section 602 must provide that the State agency shall make available to applicants for and recipients of supplementary security income benefits under title XVI at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which

the Secretary finds, after reasonable notice and opportunity for hearing to the State agency, administering or supervising the administration of such plan, that—

(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (1) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (1) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (2) of such subsection.

(d) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures in the State from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.

Operation of State Plans

Sec. 604. *If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—*

(1) that the plan no longer complies with the provisions of section 602; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no

longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Definition

Sec. 605. *For purposes of this title, the term "services to the aged, blind, or disabled" means services (including but not limited to the services referred to in Section 603(a)(1)(A) and (B)) provided for or on behalf of needy individuals who are 65 years of age or older or are blind, or are disabled.*

* * * * *

TITLE X—GRANTS TO STATES FOR AID TO THE BLIND

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Appropriation

Section 1001. For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals who are blind and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title, The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the blind.

State Plans for Aid to the Blind

Sec. 1002. (a) A State plan for aid to the blind must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the blind is denied or is not acted upon with reasonable promptness; (5) provide (A) such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low-income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; and (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act or aid to families with dependent children under the State plan approved under section 402 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind, as well as any expenses reasonably attributable to the earning of any such income, except that, in making such determination, the State agency (A) shall disregard the first \$85 per month of earned income, plus one-half of earned income in excess of \$85 per month, (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, and (C) may, before disregarding the amounts referred to in clauses (A) and (B), disregard not more than \$7.50 of any income; (9) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to the blind; (10) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (11) effective July 1, 1951, provide that all individuals wishing to make application for aid to the blind shall have opportunity to do so, and that aid to the blind shall be furnished with reasonable promptness to all eligible individuals; (12) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; and (13) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of aid to the blind to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services.

[(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the blind under the plan—

[(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid and has resided therein continuously for one year immediately preceding the application; or

[(2) Any citizenship requirement which excludes any citizen of the United States.

In the case of any State (other than Puerto Rico and the Virgin

Islands) which did not have on January 1, 1949, a State plan for aid to the blind approved under this title, the Secretary shall approve a plan of such State for aid to the blind for purposes of this title, even though it does not meet the requirements of clause (8) of subsection (a) of this section, if it meets all other requirements of this title for an approved plan for aid to the blind; but payments under section 1003 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1003 under a plan approved under this section without regard to the provisions of this sentence.

[Payments to States

[Sec. 1003. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to the blind under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

[(A) $\frac{31}{37}$ of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$37 multiplied by the total number of recipients of aid to the blind for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received aid to the blind in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the blind in the form of medical or any other type of remedial care); plus

[(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of \$75 multiplied by the total number of such recipients of aid to the blind for such month; and

[(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of aid to the blind for such month; and

[(3) in the case of any State whose State plan approved under

section 1002 meets the requirements of subsection (c)(1) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind to help them attain or retain capability for self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the blind, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

[(C) one-half of the remainder of such expenditures.

The services referred to in subparagraph (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) subject to limitations prescribed by the Secretary,

services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

[(4) in the case of any State whose State plan approved under section 1002 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.

[(b) The method of computing and paying such amounts shall be as follows:

[(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of blind individuals in the State, and (C) such other investigation as the Secretary may find necessary.

[(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as deter-

mined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the blind furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

[(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

[(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1002 must provide that the State agency shall make available to applicants for or recipients of aid to the blind at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearings to the State agency administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision, the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.

【Operation of State Plans

【Sec. 1004. In the case of any State plan for aid to the blind which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

[(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1002(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

[(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1002(a) to be included in the plan; the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[Administration

[Sec. 1005. Executed. Authorized appropriation for administrative expenses of the Social Security Board for the fiscal year ending June 30, 1936.

[Definition

[Sec. 1006. For the purpose of this title, the term "aid to the blind" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, blind individuals who are needy, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1002 includes provision for—

[(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

[(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

[(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

[(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination

of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

[(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.]

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PART A—GENERAL PROVISIONS

Definitions

Section 1101. (a) When used in this Act—

(1) The term “State”, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles **[I,] IV, V, VII, [X,] XI, [XIV,] XV, XVI, [and] XIX, XX, and XXI** includes the Virgin Islands and Guam. *Such term when used in title V also includes American Samoa and the Trust Territory of the Pacific Islands.*

(2) The term “United States” when used in a geographical sense means, except when otherwise provided, the States.

(3) The term “person” means an individual, a trust or estate, a partnership, or a corporation.

(4) The term “corporation” includes associations, joint-stock companies, and insurance companies.

(5) The term “shareholder” includes a member in an association, joint-stock company, or insurance company.

(6) The term “Secretary”, except when the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(7) The terms “physician” and “medical care” and “hospitalization” include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

[(8)(A)] The “Federal percentage” for any State (other than Puerto Rico, the Virgin Islands, and Guam) shall be 100 per centum less the State percentage; and the State percentage shall be that per-

centage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States; except that the Federal percentage shall in no case be less than 50 per centum or more than 65 per centum.]

(B) The Federal *social service* percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Secretary shall promulgate such percentage as soon as possible after the enactment of the Social Security Amendments of [1958] 1972, which promulgation shall be conclusive for each of the [eleven] ten quarters in the period beginning [October 1, 1958] January 1, 1973, and ending with the close of June 30, [1961] 1975.

(C) The term "United States" means (but only for purposes of subparagraphs (A) and (B) of this paragraph) the fifty States and the District of Columbia.

(D) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the "United States". Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

(b) The terms "includes" and "including" when used in a definition contained in this Act shall not be deemed to exclude other things otherwise within the meaning of the term defined.

(c) Whenever under this Act or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this Act the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

(d) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

Rules and Regulations

Sec. 1102. The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, respectively, shall make and publish such rules and regulations, not inconsistent

with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act; *except that no rule or regulation which affects title IV, VI, or XV of this Act shall be adopted unless such rule or regulation is related to a specific provision in such title and no rule or regulation so adopted shall be inconsistent with any provision of such title.*

Separability

Sec. 1103. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Reservation of Power

Sec. 1104. The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

Short Title

Sec. 1105. This Act may be cited as the "Social Security Act."

Disclosure of Information in Possession of Department

Sec. 1106. (a) No disclosure of any return or portion of a return (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act or under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, or under chapter 2 or 21 or, pursuant thereto, under subtitle F of the Internal Revenue Code of 1954, or under regulations made under authority thereof, which has been transmitted to the Secretary of Health, Education, and Welfare by the Commissioner of Internal Revenue, or of any file, record, report, or other paper, or any information, obtained at any time by the Secretary or by any officer or employee of the Department of Health, Education, and Welfare in the course of discharging the duties of the Secretary under this Act, and no disclosure of any such file, record, report, or other paper, or information, obtained at any time by any person from the Secretary or from any officer or employee of the Department of Health, Education, and Welfare, shall be made except as the Secretary may by regulations prescribe. Any person who shall violate any provision of this section shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding \$1,000, or by imprisonment not exceeding one year, or both *and except as provided in part D of title IV of this Act.*

(b) Requests for information, disclosure of which is authorized by regulations prescribed pursuant to subsection (a) of this section, and requests for services, may, subject to such limitations as may be prescribed by the Secretary to avoid undue interference with his functions under this Act, be complied with if the agency, person, or organization making the request agrees to pay for the information or services requested in such amount, if any (not exceeding the cost of furnishing

the information or services), as may be determined by the Secretary. Payments for information or services furnished pursuant to this section shall be made in advance or by way of reimbursement, as may be requested by the Secretary, and shall be deposited in the Treasury as a special deposit to be used to reimburse the appropriations (including authorizations to make expenditures from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund) for the unit or units of the Department of Health, Education, and Welfare which furnished the information or services. *Notwithstanding the preceding provisions of this subsection, requests for information made pursuant to the provisions of part D of title IV of this Act for the purpose of using Federal records for locating parents shall be complied with and the cost incurred in providing such information shall be paid for as provided in such part D of title IV.*

[(c) (1) (A) Upon request (filed in accordance with paragraph (2) of this subsection) of any State or local agency participating in administration of the State plan approved under title I, X, XIV, XVI or XIX, or part A of title IV, or participating in the administration of any other State or local public assistance program, for the most recent address of any individual included in the files of the Department of Health, Education, and Welfare maintained pursuant to section 205, the Secretary shall furnish such address, or the address of the most recent employer, or both, if such agency certifies that—

[(i) an order has been issued by a court of competent jurisdiction against such individual for the support and maintenance of his child or children who are under the age of 16 in destitute or necessitous circumstances.

[(ii) such child or children are applicants for or recipients of assistance available under such a plan or program,

[(iii) such agency has attempted without success to secure such information from all other sources reasonably available to it, and

[(iv) such information is requested (for its own use, or on the request and for the use of the court which issued the order) for the purpose of obtaining such support and maintenance.

[(B) If a request for the most recent address of any individual so included is filed (in accordance with paragraph (2) of this subsection) by a court having jurisdiction to issue orders or entertain petitions against individuals for the support and maintenance of their children, the Secretary shall furnish such address, or the address of the individual's most recent employer, or both, for the use of the court (and for no other purpose) in issuing or determining whether to issue such an order against such individual or in determining (in the event such individual is not within the jurisdiction of the court) the court to which a petition for support and maintenance against such individual should be forwarded under any reciprocal arrangements with other States to obtain or improve court orders for support, if the court certifies that the information is requested for such use.

[(2) A request under paragraph (1) shall be filed in such manner and form as the Secretary may prescribe (and, in the case of a request under paragraph (1) (A), shall be accompanied by a certified copy of the order referred to in clauses (i) and (iv) thereof).

[(3) The penalties provided in the second sentence of subsection (a) shall apply with respect to use of information provided under paragraph (1) of this subsection except for the purpose authorized by subparagraph (A) (iv) or (B) thereof.]

[(4) The Secretary, in such cases and to such extent as he may prescribe in accordance with regulations, may require payment for the cost of information provided under paragraph (1); and the provisions of the second sentence of subsection (b) shall apply also with respect to payment under this paragraph.]

(d) Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under title XIX and shall, subject to the limitations contained in subsection (e), make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by titles XVIII and XIX—

(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

(e) No report described in subsection (d) shall be made public by the Secretary or the State title XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be.¹

Penalty for Fraud

Sec. 1107. (a) Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this Act, subchapter E of chapter 1 or subchapter A, C, or E of chapter 9 of the Internal Revenue Code of 1939, or chapter 2, 21, or 23 or section 6011(a), 6017, or 6051(a) of the Internal Revenue Code of 1954 or of any rules or regulations issued

¹ Applies with respect to reports completed by the Secretary after the third calendar month following enactment.

thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding \$1,000, or by imprisonment not exceeding one year, or both.

(b) Whoever, with the intent to elicit information as to the date of birth, employment, wages, or benefits of any individual (1) falsely represents to the Secretary of Health, Education, and Welfare that he is such individual, or the wife, husband, widow, widower, former wife divorced, child, or parent of such individual, or the duly authorized agent of such individual, or of the wife, husband, widow, widower, former wife divorced, child, or parent of such individual, or (2) falsely represents to any person that he is an employee or agent of the United States, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding \$1,000, or by imprisonment not exceeding one year, or both.

Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam

Sec. 1108. (a) The total amount certified by the Secretary of Health, Education, and Welfare under title I, X, XIV, and XVI, and under part A of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

- (1) for payment to Puerto Rico shall not exceed—
 - (A) \$12,500,000 with respect to the fiscal year 1968,
 - (B) \$15,000,000 with respect to the fiscal year 1969,
 - (C) \$18,000,000 with respect to the fiscal year 1970,
 - (D) \$21,000,000 with respect to the fiscal year 1971, or
 - (E) \$24,000,000 with respect to the fiscal year 1972 and each fiscal year thereafter:
- (2) for payment to the Virgin Islands shall not exceed—
 - (A) \$425,000 with respect to the fiscal year 1968,
 - (B) \$500,000 with respect to the fiscal year 1969,
 - (C) \$600,000 with respect to the fiscal year 1970,
 - (D) \$700,000 with respect to the fiscal year 1971, or
 - (E) \$800,000 with respect to the fiscal year 1972 and each fiscal year thereafter: and
- (3) for payment to Guam shall not exceed—
 - (A) \$575,000 with respect to the fiscal year 1968,
 - (B) \$690,000 with respect to the fiscal year 1969,
 - (C) \$825,000 with respect to the fiscal year 1970,
 - (D) \$960,000 with respect to the fiscal year 1971, or
 - (E) \$1,100,000 with respect to the fiscal year 1972 and each fiscal year thereafter.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

- (1) for payment to Puerto Rico shall not exceed \$2,000,000,
 - (2) for payment to the Virgin Islands shall not exceed \$35,000,
- and
- (3) for payment to Guam shall not exceed \$90,000.

(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed **[\$20,000,000]**
\$30,000,000,¹

(2) for payment to the Virgin Islands shall not exceed **[\$650,000]**
\$1,000,000,¹ and

(3) for payment to Guam shall not exceed \$900,000.

(d) Notwithstanding the provisions of sections 502(a) and 512(a) of this Act, and the provisions of sections 421, 503(1), and 504(1) of this Act as amended by the Social Security Amendments of 1967, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam, *American Samoa, and the Trust Territory of the Pacific Islands* as he may deem appropriate.

Amounts Disregarded Not To Be Taken Into Account in Determining Eligibility of Other Individuals

Sec. 1109. Any amount which is disregarded (or set aside for future needs) in determining the eligibility of and amount of the aid or assistance for any individual under a State plan approved under title **[I, X, XIV]** **XV, XI, XVI, XIX,** or part A of title IV, shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such titles.

Cooperative Research or Demonstration Projects

Sec. 1110. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, \$5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (1) making grants to States and public and other nonprofit organizations and agencies for payment part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto, and (2) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters. *Of the funds appropriated under the preceding sentence for any fiscal year commencing after June 30, 1972, not less than 50 per centum thereof shall be used in projects relating to the prevention and reduction of dependency.*

(b) No contract or jointly financed cooperative arrangement shall be entered into, and no grant shall be made, under subsection (a), until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed project as to soundness of their design, the possibilities of securing productive results, the adequacy of resources to conduct the proposed research or

¹ Effective beginning fiscal year 1972.

demonstrations, and their relationship to other similar research or demonstrations already completed or in process.

(c) Grants and payments under contracts or cooperative arrangements under subsection (a) may be made either in advance or by way of reimbursement, as may be determined by the Secretary; and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purposes of this section.

Public Assistance Payments to Legal Representatives

Sec. 1111. For purposes of title [I, X, XIV,] XV[, and XVI,] and Part A of title IV, payments on behalf of an individual, made to another person who has been judicially appointed, under the law of the State in which such individual resides, as legal representative of such individual for the purpose of receiving and managing such payments (whether or not he is such individual's legal representative for other purposes), shall be regarded as money payments to such individual.

Medical Care Guides and Reports for Public Assistance and Medical Assistance

Sec. 1112. In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this Act and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section.

Assistance for United States Citizens Returned From Foreign Countries

Sec. 1113. (a) (1) The Secretary is authorized to provide temporary assistance to citizens of the United States and to dependents of citizens of the United States, if they (A) are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of the destitution of the citizen of the United States or the illness of such citizen or any of his dependents or because of war, threat of war, invasion, or similar crisis, and (B) are without available resources.

(2) Except in such cases or classes of cases as are set forth in regulations of the Secretary, provision shall be made for reimbursement to the United States by the recipients of the temporary assistance to cover the cost thereof.

(3) The Secretary may provide assistance under paragraph (1)

directly or through utilization of the services and facilities of appropriate public or private agencies and organizations, in accordance with agreements providing for payment, in advance or by way of reimbursement, as may be determined by the Secretary, of the cost thereof. Such cost shall be determined by such statistical, sampling, or other method as may be provided in the agreement.

(b) The Secretary is authorized to develop plans and make arrangements for provision of temporary assistance within the United States to individuals specified in subsection (a) (1). Such plans shall be developed and such arrangements shall be made after consultation with the Secretary of State, the Attorney General, and the Secretary of Defense. To the extent feasible, assistance provided under subsection (a) shall be provided in accordance with the plans developed pursuant to this subsection, as modified from time to time by the Secretary.

(c) For purposes of this section, the term "temporary assistance" means money payments, medical care, temporary billeting, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services) furnished to them within the United States upon their arrival in the United States and for such period after their arrival as may be provided in regulations of the Secretary.

(d) No temporary assistance may be provided under this section after June 30, 1973.

Appointment of Advisory Council and Other Advisory Groups

Sec. 1114. (a) The Secretary shall, during 1964, appoint an Advisory Council on Public Welfare for the purpose of reviewing the administration of the public assistance and child welfare services programs for which funds are appropriated pursuant to this Act and making recommendations for improvement of such administration, and reviewing the status of and making recommendations with respect to the public assistance programs for which funds are so appropriated, especially in relation to the old-age, survivors, and disability insurance program, with respect to the fiscal capacities of the States and the Federal Government, and with respect to any other matters bearing on the amount and proportion of the Federal and State shares in the public assistance and child welfare services programs.

(b) The Council shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and shall consist of twelve persons who shall, to the extent possible, be representatives of employers and employees in equal numbers, representatives of State or Federal agencies concerned with the administration or financing of the public assistance and child welfare services programs, representatives of non-profit private organizations concerned with social welfare programs, other persons with special knowledge, experience, or qualifications with respect to such programs, and members of the public.

(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical,

and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

(d) The Council shall make a report of its findings and recommendations (including recommendations for changes in the provisions of the Social Security Act) to the Secretary, such report to be submitted not later than July 1, 1966, after which date such Council shall cease to exist.

(e) The Secretary shall also from time to time thereafter appoint an Advisory Council on Public Welfare, with the same functions and constituted in the same manner as prescribed for the Advisory Council in the preceding subsections of this section. Each Council so appointed shall report its findings and recommendations, as prescribed in subsection (d), not later than July 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist.

(f) The Secretary may also appoint, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, such advisory committees as he may deem advisable to advise and consult with him in carrying out any of his functions under this Act. The Secretary shall report to the Congress annually on the number of such committees and on the membership and activities of each such committee.

(g) Members of the Council or of any advisory committee appointed under this section who are not regular full-time employees of the United States shall, while serving on business of the Council or any such committee be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$75 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code for persons in Government service employed intermittently.

(h) (1) Any member of the Council or any advisory committee appointed under this Act, who is not a regular full-time employee of the United States, is hereby exempted, with respect to such appointment, from the operation of sections 281, 283, and 1914 of title 18 of the United States Code, and section 190 of the Revised Statutes (5 U.S.C. 99), except as otherwise specified in paragraph (2) of this subsection.

(2) The exemption granted by paragraph (1) shall not extend—

(A) to the receipt or payment of salary in connection with the appointee's Government service from any source other than the employer of the appointee at the time of his appointment, or

(B) during the period of such appointment, to the prosecution or participation in the prosecution, by any person so appointed, of any claim against the Government involving any matter with which such person, during such period, is or was directly connected by reason of such appointment.

Demonstration Projects

Sec. 1115. In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in

promoting the objectives of title [I, X, XIV, XVI] VI, XV, or XIX, or part A of title IV, in a State or States—

(a) the Secretary may waive compliance with any of the requirements of [section 2, 402, 1002, 1402, 1602, or] title VI, or XV, part A of title IV, or section 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(b) costs of such project which would not otherwise be included as expenditures under section [3, 403, 1003, 1403, 1603,] 412, 603, 1506, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate.

In addition, not to exceed \$4,000,000 of the aggregate amount appropriated for payments to States under such titles for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such project as is not covered by payments under such titles and is not included as part of the cost of projects for purposes of section 1110. *Not less than 50 per centum of the amounts made available to the States under this section, for any fiscal year beginning after June 30, 1972, shall be used in projects relating to the prevention and reduction of welfare dependency.*

Administrative and Judicial Review of Certain Administrative Determinations

Sec. 1116. (a) (1) Whenever a State plan is submitted to the Secretary by a State for approval under title [I, X, XIV, XVI] VI, XV or XIX, or part A of title IV, he shall not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section [4, 404, 1004, 1404, 1604] 413, 603, 1506.

or 1904 may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive: but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(b) For the purposes of subsection (a), any amendment of a State plan approved under title **[I, X, XIV, XVI]** *VI, XV, or XIX*, or part A of title IV, may, at the option of the State, be treated as the submission of a new State plan.

(c) Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title **[I, X, XIV, XVI]** *VI, XV, or XIX*, or part A of title IV, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

[Alternative Federal Payment With Respect to Public Assistance Expenditures

[Sec. 1118. In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with June 30), under paragraphs (1) and (2) of sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, X, XIV, and XVI, and part A of title IV, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections.]

Federal Participation in Payments for Repairs to Home Owned by Recipient of Aid or Assistance

Sec. 1119. In the case of an expenditure for repairing the home owned by an individual who is receiving [aid or assistance, other than medical assistance to the aged under a State plan approved under title I, X, XIV or XVI] *payments under a State plan approved under title XV or XVI, or part A of title IV if—*

(1) the State agency or local agency administering the plan approved under such title has made a finding (prior to making such expenditure) that (A) such home is so defective that continued occupancy is unwarranted, (B) unless repairs are made to such home, rental quarters will be necessary for such individual, and (C) the cost of rental quarters to take care of the needs of such individual (including his spouse living with him in such home and any other individual whose needs were taken into account in determining the need of such individual) would exceed (over such time as the Secretary may specify) the cost of repairs needed to make such home habitable together with other costs attributable to continued occupancy of such home, and

(2) no such expenditures were made for repairing such home pursuant to any prior finding under this section, the amount paid to any such State for any quarter under section [3 (a), 403 (a), 1003 (a), 1403 (a), or 1603 (a)] *412, or 1506*, shall be increased by 50 per centum of such expenditures, except that the excess above \$500 expended with respect to any one home shall not be included in determining such expenditures.

Approval of Certain Projects

Sec. 1120. (a) No payment shall be made under this Act with respect to any experimental, pilot, demonstration, or other project all or any part of which is wholly financed with Federal funds made available under this Act (without any State, local, or other non-Federal financial participation) unless such project shall have been personally approved by the Secretary or Under Secretary of Health, Education, and Welfare.

(b) As soon as possible after the approval of any project under subsection (a), the Secretary shall submit to the Congress a description of such project including a statement of its purpose, probable cost, and expected duration.

Sec. 1121. [Repealed.]

Limitation on Federal Participation for Capital Expenditures¹

Sec. 1122. (a) *The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of*

¹ Applies only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility or health maintenance organization subsequent to whichever of the following is earlier: (A) December 31, 1972, or (B) with respect to any State or any part thereof specified by such State, the last day of the calendar quarter in which the State requests that the amendment made by subsection (a) of this section apply in such State or such part thereof.

health care facilities or health maintenance organizations which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least 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 or health maintenance organization in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations in such State within the fields of their respective responsibilities, 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 an 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 to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent 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 so developed.

(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

(B)(i) the planning agency so designated or an agency so

described had received such timely notice of the intention to make such capital expenditure and had within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

(I) consulted, with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is 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. With respect to any organization which is reimbursed on a per capita basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective adminis-

tration of title V, XVIII, or XIX, he shall not exclude such expenses pursuant to paragraph (1).

(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds \$100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds \$100,000.

(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall

be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS-18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently.

Program for Determining Qualifications for Certain Health Care Personnel

SEC. 1123. (a) *The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, 1977, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, technologists, cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.*

(b) *If any individual has been determined, under the program established pursuant to subsection (a), to be qualified to perform the duties and functions of any health care specialty, no person or provider utilizing the services of such individual to perform such duties and functions shall be denied payment, under title XVIII or under any State plan approved under title XIX, for any health care services provided by such person on the grounds that such individual is not qualified to perform such duties and functions.*

Inspector General for Health Administration

SEC. 1124. (a) (1) *In addition to other officers within the Department of Health, Education, and Welfare, there shall be, within such*

Department, an officer with the title of "Inspector General for Health Administration" (hereinafter in this section referred to as the "Inspector General"), who shall be appointed or reappointed by the President, by and with the advice and consent of the Senate. In addition, there shall be a Deputy Inspector General for Health Administration (hereinafter referred to as the "Deputy Inspector General"), and such additional personnel as may be required to carry out the functions vested in the Inspector General by this section.

(2) The term of office of any individual appointed or reappointed to the position of Inspector General shall expire 6 years after the date he takes office pursuant to such appointment or reappointment.

(b) The Inspector General shall report directly to the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary"); and, in carrying out the functions vested in him by this section, the Inspector General shall not be under the control of, or subject to supervision by, any officer of the Department of Health, Education, and Welfare, other than the Secretary.

(c) (1) It shall be the duty and responsibility of the Inspector General to arrange for, direct, or conduct such reviews, inspections, and audits of the health insurance program established by title XVIII, the medical assistance programs established pursuant to title XIX, and any other programs of health care authorized under any other title of this Act as he considers necessary for ascertaining the efficiency and economy of their administration, their consonance with the provisions of law by or pursuant to which such programs were established, and the attainment of the objectives and purposes for which such provisions of law were enacted.

(2) The Inspector General shall maintain continuous observation and review of programs with respect to which he has responsibilities under paragraph (1) of this subsection for the purpose of—

(A) determining the extent to which such programs are in compliance with applicable laws and regulations;

(B) making recommendations for the correction of deficiencies in, or for improving the organization, plans, procedures, or administration of, such programs; and

(C) evaluating the effectiveness of such programs in attaining the objectives and purposes of the provisions of law by or pursuant to which such programs were established.

(d) (1) For purposes of aiding in carrying out his duties under this section, the Inspector General shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which relate to the programs with respect to which the Inspector General has responsibilities under this section.

(2) The head of any Federal department, agency, office, or instrumentality shall, and the head of any State agency administering or supervising the administration of any State plan approved under title XIX shall, at the request of the Inspector General, provide any information which the Inspector General determines will be helpful to him in carrying out his responsibilities under this section.

(e) (1) The Inspector General shall have authority to suspend any regulation, practice, or procedure employed in the administration of

any program with respect to which he has responsibilities under this section if, as a result of any study, investigation, review, or audit of such program, he determines that—

(A) the suspension of such regulation, practice, or procedure will promote efficiency or economy in the administration of such program; or

(B) such regulation, practice, or procedure is contrary to applicable provisions of law, or does not carry out the objectives and purposes of the provisions of law by or pursuant to which there was established the program in connection with which such regulation, practice, or procedure is promulgated, instituted, or applied.

(2)(A) Any order of suspension by the Inspector General of any regulation, practice, or procedure pursuant to this subsection shall remain in effect until the Inspector General issues an order reinstating such regulation, practice, or procedure; except that the Secretary shall receive not less than 30 days notice of the proposed suspension and may, at any time prior to or after any such suspension by the Inspector General, issue an order revoking such suspension.

(B) Whenever the Secretary issues an order revoking any such actual or proposed order of suspension by the Inspector General, he shall promptly notify the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives (and, in case such order relates to any State regulation, practice, or procedure employed by a State in the administration of its State plan approved under title XIX, the Governor, or other chief executive officer, of such State) of such order and shall submit to each such committee information explaining his reasons for the issuance of such order.

(f) If—

(1) the Inspector General issues any order suspending any State regulation, practice, or procedure employed by a State in the administration of its State plan approved under title XIX, and

(2) for any period that such order is in effect, such State fails to comply with such order, then, notwithstanding any other provision of law, the amount of the Federal payments otherwise payable to such State under section 1903 with respect to such period shall be reduced by an amount equal to the amount (if any) of the excess of—

(3) the amount of Federal funds payable to such State with respect to such period under section 1903, as determined without regard to this subsection, over

(4) the amount of the Federal funds which would have been payable to such State under such section with respect to such period if, for all of such period, such State had complied with such order.

For purposes of the preceding sentence, an order of the Inspector General shall not be deemed to be in effect for any period if such order has been revoked by an order of the Secretary issued in accordance with subsection (e) (2).

(g)(1) The Inspector General may, from time to time, submit such reports to the Committee on Finance of the Senate and the Com-

mittee on Ways and Means of the House of Representatives relating to his activities as he deems to be appropriate.

(2) Whenever either of the committees referred to in paragraph (1) makes a request to the Inspector General to furnish such committee with any information, or to conduct any study or investigation and report the findings resulting therefrom to such committee, the Inspector General shall comply with such request.

(3) Whenever the Inspector General issues an order suspending or reinstating any regulation, practice, or procedure pursuant to subsection (e), he shall promptly notify the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives (and, in case such order relates to any State regulation, practice or procedure employed by a State in the administration of its State plan approved under title XIX, the Governor, or other chief executive officer, of such State) of such order and shall submit to each such Committee information explaining his reasons for the issuance of such order.

(h) The Inspector General may make expenditures (not in excess of \$50,000 in any fiscal year) of a confidential nature when he finds that such expenditures are in aid of inspections, audits, or reviews under this section; but such expenditures so made shall not be utilized to make payments, to any one individual, the aggregate of which exceeds \$2,000. The Inspector General shall submit annually a confidential report on expenditures under this provision to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(i) (1) Expenses of the Inspector General relating to the health insurance program established by title XVIII shall be payable from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, with such portions being paid from each such Fund as the Secretary shall deem to be appropriate. Expenses of the Inspector General relating to medical assistance programs established pursuant to title XIX shall be payable from funds appropriated to carry out such title; and expenses of the Inspector General relating to any program of health care authorized under any title of this Act (other than titles XVIII and XIX) shall be payable from funds appropriated to carry out such program.

(2) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(j) The Secretary shall provide the Inspector General and his staff with appropriate and adequate office space within the facilities of the Department of Health, Education, and Welfare, together with such equipment, office supplies, and communications facilities and services, as may be necessary for the operation of such office and shall provide necessary maintenance services for such office and the equipment and facilities located therein.

Authorization and Allotment of Appropriations for Services

Sec. 1125. (a) There are authorized to be appropriated for each fiscal year beginning after June 30, 1972, for payments to States under sections 412 and 1609 with respect to services to families with depend-

ent children (as defined in section 407(b) but not including services described in clause (1) or (2) of such subsection) and services to the aged, blind, or disabled (as defined in section 1607(b)), \$1,000,000,000.

(b) From the sums appropriated pursuant to subsection (a), the Secretary shall allot to each State (other than Puerto Rico, the Virgin Islands, and Guam) an amount which bears the same ratio to the amount so appropriated as the population of such State bears to the total population of all the States.

(c) The amount of any allotment for any fiscal year pursuant to subsection (b) which the Secretary determines will not be required for providing the services described in subsection (a) for such fiscal year shall be available for reallocation, for the purposes for which it was originally made available, from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines have need in providing such services of amounts in excess of those previously allotted to them under subsection (b).

(2) after the allotment pursuant to paragraph (1) has been made, from the sums remaining (if any) not in excess of \$50,000,000, the Secretary shall allot to each State which has a service deficit (as defined in the last sentence of this subsection) an amount which bears the same ratio to such sums remaining as such deficit bears to the total of the service deficits of all the States having such deficits; and

(3) after the allotment pursuant to paragraph (2) has been made, from the sums remaining (if any), the Secretary shall allot to each State an amount which bears the same ratio to such sums remaining as the number of individuals receiving benefits under sections 2011 and 2102 in such State bears to the number of such individuals in all the States.

As used in paragraph (2), the term "service deficit", with respect to any State, means the amount by which (i) the average service expenditure (as defined in subsection (d)) per recipient of benefits under sections 2011 and 2102 in such State is less than (ii) the average of the expenditures for training and services under titles [I, X, XIV and] ¹ XVI and part A of title IV in all the States (other than child care and family planning services under such part) multiplied by the number of recipients of such benefits in such State.

Criminal Offenses by Welfare Employees

SEC. 1126. Any officer or employee of the United States or of any State or of any political subdivision of such State acting in connection with the administration or operation of any State plan approved under title IV, XV, or XVI, of this Act—

(1) who is guilty of any extortion or willful oppression under color of State or Federal law; or

(2) who knowingly allows the disbursement of greater sums than are authorized by law, or receives any fee, compensation, or reward, except as by law prescribed, for the performance of any duty; or

¹ Deleted effective January 1, 1973.

(3) who, with intent to defeat the application of any provision of title IV, XV, or XVI, of the Social Security Act or any State plan approved thereunder, fails to perform any of the duties of his office or employment; or

(4) who conspires or colludes with any other person to defraud the United States, any State government, or any political subdivision of such State; or

(5) who knowingly makes opportunity for any person to defraud the United States, any State government, or any political subdivision of such State; or

(6) who does or omits to do any act with intent to enable any other person to defraud the United States, any State government, or any political subdivision of such State;

(7) who makes or signs any fraudulent entry in any book, or makes or signs any fraudulent application, form, or statement, knowing it to be fraudulent; or

(8) who, having knowledge or information of fraud committed by any person against the United States, any State government, or any political subdivision of such State under title IV, XV, or XVI, of the Social Security Act or any State plan approved thereunder, fails to report, in writing, such knowledge or information to the Secretary or his delegate, or, if the fraud is against a State government or any political subdivision of such State, to the individual designated to administer the State plan approved under such title or his delegate; or

(9) who demands, or accepts, or attempts to collect directly or indirectly as payment or gift, or otherwise, any sum of money or other thing of value for the compromise, adjustment, or settlement of any charge or complaint for any violation or alleged violation of law, except as expressly authorized by law so to do; shall be dismissed from office or discharged from employment and, upon conviction thereof, shall be fined not more than \$10,000, or imprisoned not more than 5 years, or both.

Prohibition Against Use of Federal Funds to Undermine Programs Under the Social Security Act

SEC. 1127. (a) (1) Subject to paragraph (2), no Federal funds shall be used (whether directly or indirectly) to pay all or any part of the compensation or expenses of any attorney or other person who, as a part of his federally financed activity whether as an employee in the executive branch or under a grant or contractual arrangement with the executive branch (or other employment), engages in any activity, for or on behalf of any client or other person or class of persons, the purpose of which is (by litigation or by actions related thereto) to nullify, challenge, or circumvent any provision of the Social Security Act, or any of the purposes or intentions of the Congress in enacting any such title or provision thereof or relating thereto; and it shall be unlawful for any such attorney or other person who engages in any such federally financed activity to accept or receive any Federal funds to defray all or any part of his compensation.

(2) The prohibition contained in paragraph (1) shall not apply to

any particular case or lawsuit (or to any attorney or other person involved therein) if the Attorney General issues an order specifically waiving such prohibition with respect to such case or lawsuit; except that no such order shall become effective with respect to any case or lawsuit until 60 days after the Attorney General shall have submitted to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives a notice of his intention to waive such prohibition with respect to such case or lawsuit.

(b) Any person who authorizes the disbursement of any Federal funds, and any attorney or other person who receives or accepts any such funds, in violation of subsection (a), shall be held accountable for and required to make good to the United States the amount of funds so disbursed or received or accepted.

Limitation on Authority of Secretary With Respect to Advisory Councils

SEC. 1128. Nothing in this Act shall be construed to authorize or permit the Secretary of Health, Education, and Welfare to prescribe any rule or regulation requiring any State, in the operation of a State plan approved under title IV, VI or XVI of this Act, to establish or pay the expenses of any advisory council to advise the State with respect to such plan, its operation, or any program or programs conducted thereunder.

Evaluation of Social Security Programs

SEC. 1129. (a) (1) The Comptroller General is hereby authorized to make analyses and evaluations of programs under this Act.

(2) The departments and agencies shall make available to the Comptroller General such information and documents as he considers necessary for him to complete his work under this subsection.

(b) (1) No department or agency of the Federal Government shall enter into any contract for the conduct of, or employ any expert or consultant to conduct, any study or evaluation of any program which—

(A) is established by or pursuant to this Act, or

(B) receives Federal financial assistance pursuant to authority contained in this Act,

if the conduct of such study or evaluation involves the expenditure, from Federal funds, of an amount in excess of \$25,000, unless, prior to the commencement of such study or evaluation, such department or agency shall have requested of, and obtained from, the Comptroller General approval for the conduct of such study or evaluation.

(2) The Comptroller General shall not approve any request for the conduct of any study or evaluation of any program under paragraph (1), unless he determines that—

(A) the conduct of such study or evaluation of such program is justified;

(B) such department or agency cannot effectively conduct such study or evaluation through utilization of regular full-time employees of such department or agency; and

(C) such study or evaluation will not be duplicative of any

study or evaluation which is being conducted, or will be conducted within the next twelve months, by the General Accounting Office.

(c) (1) *To assist in carrying out his functions under this section, the Comptroller General may sign and issue subpoenas requiring the production of negotiated contract and subcontract records and records of other non-Federal persons or organizations to which he has a right of access by law or agreement.*

(2) *In case of disobedience to a subpoena issued under the authority contained in paragraph (1), the Comptroller General may invoke the aid of any district court of the United States in requiring the production of the records referred to in paragraph (1). Any district court of the United States within the jurisdiction in which the contractor, subcontractor, or other non-Federal person or organization is found or resides or in which the contractor, subcontractor, or other non-Federal person or organization transacts business may, in case of contumacy or refusal to obey a subpoena issued by the Comptroller General, issue an order requiring the contractor, subcontractor, or other non-Federal person or organization to produce the records; and any failure to obey such order of the court shall be punished by the court as a contempt thereof.*

Limitation on Funds for Certain Social Services

SEC. 1130. (a) *Notwithstanding the provisions of section [3(a)(4) and (5), 412(a)(3), 1003(a)(3) and (4), 1403(a)(3) and (4), 1505(a)(2), or 1603(a)(4) and (5)] → 412(a)(3), 603(a), or 1505(a)(2) ←,¹ amounts payable for any fiscal year (commencing with the fiscal year beginning July 1, 1972) under such section (as determined without regard to this section) to any State with respect to expenditures made after June 30, 1972 for services referred to in such section (other than [the services provided pursuant to section 409(f), other than] family planning services, and other than services described in section 412(a)(3)(C)(ii) or 412(a)(3)(E)(i)) shall be reduced by such amounts as may be necessary to assure that—*

(1) *the total amount paid to such State (under all of such sections) for such fiscal year for such services does not exceed the allotment of such State (as determined under subsection (b)); and*

(2) *of the amounts paid (under all of such sections) to such State for such fiscal year with respect to such expenditures, other than expenditures for—*

(A) *services provided to meet the needs of a child for personal care, protection, and supervision, but only in the case of a child where the provision of such services is needed (i) in order to enable a member of such child's family to accept or continue in employment or to participate in training to prepare such member for employment, or (ii) because of the death, continued absence from the home, or incapacity of the child's mother and the inability of any member of such child's family to provide adequate care and supervision for such child;*

(B) *services provided to a mentally retarded individual (whether a child or an adult), but only if such services are*

¹ Material within brackets deleted effective Jan. 1, 1974; material between arrows added effective Jan. 1, 1974.

needed (as determined in accordance with criteria prescribed by the Secretary) by such individual by reason of his condition of being mentally retarded;

(C) services provided to an individual who is a drug addict or an alcoholic, but only if such services are needed (as determined in accordance with criteria prescribed by the Secretary) by such individual as part of a program of active treatment of his condition as a drug addict or an alcoholic; and

(D) services provided to a child who is under foster care in a foster family home (as defined in section 411(d)) or in a child-care institution (as defined in such section), or while awaiting placement in such a home or institution, but only if such services are needed (as determined in accordance with criteria prescribed by the Secretary) by such child because he is under foster care,

not more than 10 per centum thereof are paid with respect to expenditures incurred in providing services to individuals who are not recipients of aid [, assistance,] or payments [() under State plans approved under title[s I, X, XIV,] XV[, XVI,] or part A of title IV → or of supplemental security income benefits under title XVI←), or applicants (as defined under regulations of the Secretary) for such aid, [assistance, or] payments→, or benefits←.¹

(b) (1) For each fiscal year (commencing with the fiscal year beginning July 1, 1973) the Secretary shall allot to each State an amount which bears the same ratio to \$2,500,000,000 as the population of such State bears to the population of all the States.

(2) The allotment for each State shall be promulgated for each fiscal year by the Secretary between July 1 and August 31 of the calendar year immediately preceding such fiscal year on the basis of the population of each State and of all of the States as determined from the most recent satisfactory data available from the Department of Commerce at such time; except that the allotment for each State for the fiscal year beginning July 1, 1972, and the following fiscal year shall be promulgated at the earliest practicable date after the enactment of this section but not later than January 1, 1973.

(c) For purposes of this section, the term "State" means any one of the fifty States or the District of Columbia.

PART B—PROFESSIONAL STANDARDS REVIEW

Declaration of Purpose

SEC. 1151. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional stand-

¹ Material within brackets deleted effective Jan. 1, 1974; material between arrows added effective Jan. 1, 1974.

ards for the provision of health care and that payment for such services will be made—

(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

Designation of Professional Standards Review Organizations

SEC. 1152. (a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

(b) For purposes of subsection (a), the term "qualified organization" means

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(i),

(B) such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accord-

ance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan submitted to him by the association, agency, or organization (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and activities of a Professional Standards Review Organization required by or pursuant to this part.

(c) (1) The Secretary shall not enter into any agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A) unless, in such area, there is no organization referred to in subsection (b) (1) (A) which meets the conditions specified in subsection (b) (2).

(2) Whenever the Secretary shall have entered into an agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A), he shall not renew such agreements with such organization if he determines that—

(A) there is in such area an organization referred to in subsection (b) (1) (A) which (i) has not been previously designated as a Professional Standards Review Organization, and (ii) is willing to enter into an agreement under this part under which such organization would be designated as the Professional Standards Review Organization for such area;

(B) such organization meets the conditions specified in subsection (b) (2); and

(C) the designation of such organization as the Professional Standards Review Organization for such area is anticipated to result in substantial improvement in the performance in such area of the duties and functions required of such organizations under this part.

(d) Any such agreement under this part with an organization (other than an agreement established pursuant to section 1154) shall be for a term of twelve months; except that, prior to the expiration of such term such agreement may be terminated—

(1) by the organization at such time and upon such notice to the Secretary as may be prescribed in regulations (except that notice of more than three months may not be required); or

(2) by the Secretary at such time and upon such reasonable notice to the organization as may be prescribed in regulations, but only after the Secretary has determined (after providing such organization with an opportunity for a formal hearing on the matter) that such organization is not substantially complying with or effectively carrying out the provisions of such agreement.

(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise

required under or pursuant to any provisions of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise so required are not needed for the provision of adequate review and control.

Review Pending Designation of Professional Standards Review Organization

SEC. 1153. Pending the assumption by a Professional Standards Review Organization for any area, a full review responsibility, and pending a demonstration of capacity for improved review effort with respect to matters involving the provision of health care services in such area for which payment (in whole or in part) may be made, under this Act, any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

Trial Period for Professional Standards Review Organizations

SEC. 1154. (a) The Secretary shall initially designate an organization as a Professional Standards Review Organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and functions imposed under this part on Professional Standards Review Organizations. Such designation may not be made prior to receipt from such organization and approval by the Secretary of a formal plan for the orderly assumption and implementation of the responsibilities of the Professional Standards Review Organization under this part.

(b) During any such trial period (which may not exceed twenty-four months), the Secretary may require a Professional Standards Review Organization to perform only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review organizations under this part with respect to the review of health care services provided or ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law:

(c) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such organization.

Duties and Functions of Professional Standards Review Organizations

SEC. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an in-patient health care facility of a different type.

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility, or

(B) any other health care service which will consist of extended or costly courses of treatment, whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at

least one of the participating hospitals in the area served by the Professional Standards Review Organization and, (except as may be otherwise provided under subsection (e)(1) of this section) such physicians ordinarily should not be responsible for, but may participate in the review of care and services provided in any hospital in which such physicians have active staff privileges.

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly or indirectly involved in providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, and financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

(2) undertake such professional inquiry either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a) (1);

(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a) (1); and

(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

(c) No Professional Standards Review Organization shall utilize the services of any individual who is not a duly licensed doctor of medicine or osteopathy to make final determinations in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine or osteopathy, or any act performed by any duly licensed doctor of medicine or osteopathy in the exercise of his profession.

(d) In order to familiarize physicians with the review functions and activities of Professional Standards Review Organizations and to promote acceptance of such functions and activities by physicians, patients, and other persons, each Professional Standards Review Organization, in carrying out its review responsibilities, shall (to the maximum extent consistent with the effective and timely performance of its duties and functions)—

(1) encourage all physicians practicing their profession in the area served by such Organization to participate as reviewers in the review activities of such Organization;

(2) provide rotating physician membership of review committees on an extensive and continuing basis;

(3) assure that membership on review committees have the broadest representation feasible in terms of the various types of practice in which physicians engage in the area served by such Organization; and

(4) utilize, whenever appropriate, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.

(e) (1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital or other operating health care facility or organization located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a) (1), except where the Secretary disapproves, for good cause, such acceptance.

(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

(f) (1) An agreement entered into under this part between the Secretary and any organization under which such organization is designated as the Professional Standards Review Organization for any area shall provide that such organization will—

(A) perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part; and

(B) collect such data relevant to its functions and such information and keep and maintain such records in such form as the Secretary may require to carry out the purposes of this part and to permit access to and use of any such records as the Secretary may require for such purposes.

(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

Norms of Health Care Services for Various Illnesses or Health Conditions

SEC. 1156. (a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (in-

cluding typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review. The National Professional Standards Review Council and the Secretary shall provide such technical assistance to the organization as will be helpful in utilizing and applying such norms of care, diagnosis, and treatment. Where the actual norms of care, diagnosis, and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care, diagnosis, and treatment approved for comparable conditions, the Professional Standards Review Organization concerned shall be so informed, and in the event that appropriate consultation and discussion indicate reasonable basis for usage of other norms in the area concerned, the Professional Standards Review Organization may apply such norms in such area as are approved by the National Professional Standards Review Council.

(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

(c) (1) The National Professional Standards Review Council shall provide for the preparation and distribution, to each Professional Standards Review Organization and to each other agency or person performing review functions with respect to the provision of health care services under this Act, of appropriate materials indicating the regional norms to be utilized pursuant to this part. Such data concerning norms shall be reviewed and revised from time to time. The approval of the National Professional Standards Review Council of norms of care, diagnosis, and treatment shall be based on its analysis of appropriate and adequate data.

(2) Each review organization, agency, or person referred to in paragraph (1) shall utilize the norms developed under this section as a principal point of evaluation and review for determining, with respect to any health care services which have been or are proposed to be provided, whether such care and services are consistent with the criteria specified in section 1155(a)(1).

(d) (1) Each Professional Standards Review Organization shall—

(A) in accordance with regulations of the Secretary, specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and

(B) require that there be included in any such certification with

respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institutional health care recommended by the physician executing such certification.

(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures.

Submission of Reports by Professional Standards Review Organizations

Sec. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate. The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862(d)(1) and subparagraph (F) of section 1866(b)(2).

Requirement of Review Approval as Condition of Payment of Claims

Sec. 1158. (a) Except as provided for in section 1159, no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the

individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organization or agency of its disapproval in accordance with subsection (a), promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

Hearings and Review by Secretary

SEC. 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155(a) shall, after being notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is \$100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determined, revised.

(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is \$100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205 (b), and, where the amount in controversy is \$1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g). The Secretary will render a decision only after appropriate professional consultation on the matter.

(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this Act with respect to the same issue.

Obligations of Health Care Practitioners and Providers of Health Care Services; Sanctions and Penalties; Hearings and Review

SEC. 1160. (a) (1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act—

(A) will be provided only when, and to the extent, medically necessary; and

(B) will be of a quality which meets professionally recognized standards of health care; and

(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities;

and it shall be the obligation of any health care practitioner, in ordering, authorizing, directly, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency) of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

(D) only when, and to the extent, medically necessary; and

(E) will be of a quality which meets professionally recognized standards of health care.

(2) Each health care practitioner, and each hospital or other provider of health care services, shall have the obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

(B) (i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

(b) (1) If after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

(B) by grossly and flagrantly violating any such obligation in one or more instances, demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determinations shall be effective in the manner provided in title XVIII with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis) such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) \$5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

(4) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

Notice to Practitioner or Provider

SEC. 1161. Whenever any Professional Standards Review Organization takes any action or makes any determination—

(a) which denies any request, by a health care practitioner or other provider of health care services, for approval of a health care service or item proposed to be ordered or provided by such practitioner or provider; or

(b) that any such practitioner or provider has violated any obligation imposed on such practitioner or provider under section 1160,

such organization shall, immediately after taking such action or making such determination, give notice to such practitioner or provider of such determination and the basis therefor, and shall provide him with appropriate opportunity for discussion and review of the matter.

Statewide Professional Standards Review Councils; Advisory Groups to Such Councils

SEC. 1162. (a) In any State in which there are located three or more Professional Standards Review Organizations, the Secretary shall establish a Statewide Professional Standards Review Council.

(b) The membership of any such Council for any State shall be appointed by the Secretary and shall consist of—

(1) one representative from and designated by each Professional Standards Review Organization in the State;

(2) four physicians, two of whom may be designated by the State medical society and two of whom may be designated by the State hospital association of such State to serve as members on such Council; and

(3) four persons knowledgeable in health care from such State whom the Secretary shall have selected as representatives of the public in such State (at least two of whom shall have been recommended for membership on the Council by the Governor of such State).

(c) It shall be the duty and function of the Statewide Professional Standards Review Council for any State, in accordance with regulations of the Secretary, (1) to coordinate the activities of, and disseminate information and data among the various Professional Standards Review Organizations within such State including assisting the Secretary in development of uniform data gathering procedures and operating procedures applicable to the several areas in a State (including, where appropriate, common data processing operations serving several or all areas) to assure efficient operation and objective evaluation of comparative performance of the several areas and, (2) to assist the Secretary in evaluating the performance of each Professional Standards Review Organization, and (3) where the Secretary finds it necessary to replace a Professional Standards Review Organization, to assist him in developing and arranging for a qualified replacement Professional Standards Review Organization.

(d) The Secretary is authorized to enter into an agreement with any such Council under which the Secretary shall make payments to such Council equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such Council in carrying out the duties and functions provided in this section.

(e) (1) The Statewide Professional Standards Review Council for any State (or in a State which does not have such Council, the Pro-

professional Standards Review Organizations in such State which have agreements with the Secretary) shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council (or Professional Standards Review Organizations in States without such Councils).

(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such group in carrying out its duties and functions under this subsection shall be considered to be expenses necessarily incurred by the Statewide Professional Standards Review Council served by such group.

National Professional Standards Review Council

SEC. 1163. (a) (1). There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years and shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the members of the Council to serve as Chairman thereof.

(b) Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended to the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

(c) The Council is authorized to utilize, and the Secretary shall make available, or arrange for, such technical and professional consultative assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical and other assistance and such pertinent data prepared by, for, or otherwise available to, the Department of Health, Education, and Welfare as the Council may require to carry out its functions.

(d) Members of the Council, while serving on business of the Council, shall be entitled to receive compensation at a rate fixed by the Secretary (but not in excess of the daily rate paid under GS-18 of the General Schedule under section 5332 of title 5, United States Code), including traveltime; and while so serving away from their

homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(e) It shall be the duty of the Council to—

(1) advise the Secretary in the administration of this part;

(2) provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations, of information and data which will assist such review councils and organizations in carrying out their duties and functions;

(3) review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of this part; and

(4) make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of this part.

(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.

Application of This Part to Certain State Programs Receiving Federal Financial Assistance

SEC. 1164. (a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any title of this Act under which health care services are paid for in whole or part, with Federal funds, there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

(b) The requirement imposed by subsection (a) with respect to such State plans approved under this Act shall apply—

(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

(A) on and after July 1, 1974, or

(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State which begins after December 31, 1973.

Correlation of Functions Between Professional Standards Review Organizations and Administrative Instrumentalities

SEC. 1165. The Secretary shall by regulations provide for such correlation of activities, such interchange of data and information, and such other cooperation consistent with economical, efficient, coordinated, and comprehensive implementation of this part (including but not limited to, usage of existing mechanical and other data-gathering capacity) between and among—

(a) (1) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (2) carriers which are parties to contracts entered into pursuant to section 1842, and (3) any other public or private agency (other than a Professional Standards Review Organization) having review or control functions, or proved relevant data-gathering procedures and experience, and

(b) Professional Standards Review Organizations, as may be necessary or appropriate for the effective administration of title XVIII, or State plans approved under this Act.

Prohibition Against Disclosure of Information

SEC. 1166. (a) Any data or information acquired by an Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

(b) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than \$1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

Limitation on Liability for Persons Providing Information, and for Members and Employees of Professional Standards Review Organizations, and for Health Care Practitioners and Providers

SEC. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, of the United States, or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the duties and functions of such Organization, or

(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization or who furnishes professional

counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations under this part, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

(2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a Professional Standards Review Organization (which has been designated in accordance with section 1152(b)(1)(A)) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

(1) he takes such action (in the case of a health care practitioner) in the exercise of his profession as a doctor of medicine or osteopathy (or in the case of a provider of health care services) in the exercise of his functions as a provider of health care services and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

Authorization for Use of Certain Funds to Administer the Provisions of this Part

Sec. 1168. Expenses incurred in the administration of this part shall be payable from—

(a) funds in the Federal Hospital Insurance Trust Fund;

(b) funds in the Federal Supplementary Medical Insurance Trust Fund; and

(c) funds appropriated to carry out the health care provisions of the several titles of this Act;

in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c)) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs.

Technical Assistance to Organizations Desiring To Be Designated as Professional Standards Review Organizations

Sec. 1169. The Secretary is authorized to provide all necessary technical and other assistance (including the preparation of prototype plans of organization and operation) to organizations described in section 1152(b)(1) which—

(a) *express a desire to be designated as a Professional Standards Review Organization; and*

(b) *the Secretary determines to have a potential for meeting the requirements of a Professional Standards Review Organization; to assist such organizations in developing a proper plan to be submitted to the Secretary and otherwise in preparing to meet the requirements of this part for designation as a Professional Standards Review Organization.*

Exemptions of Christian Science Sanatoriums

SEC. 1170. The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

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**[TITLE XIV—GRANTS TO STATES FOR AID TO THE
PERMANENTLY AND TOTALLY DISABLED]**

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[Appropriation

[Section 1401. For the purpose of enabling each State to furnish financial assistance, as far as practicable under the condition in such State, to needy individuals eighteen years of age and older who are permanently and totally disabled and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the permanently and totally disabled.

[State Plans for Aid to the Permanently and Totally Disabled

[Sec. 1402. (a) A State plan for aid to the permanently and totally disabled must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness; (5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services

to applicants and recipients and in assisting any advisory committees established by the State agency; (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act, aid to families with dependent children under the State plan approved under section 402 of this Act, or aid to the blind under the State plan approved under section 1002 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (A) the State agency may disregard not more than \$7.50 of any income, (B) of the first \$80 per month of additional income which is earned the State agency may disregard not more than the first \$20 thereof plus one-half of the remainder, and (C) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation; (9) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to the permanently and totally disabled; (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; (11) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; and (12) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services.

[(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the permanently and totally disabled under the plan—

[(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

[(2) Any citizenship requirement which excludes any citizen of the United States.

Payments to States

[Sec. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to the permanently and totally disabled under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

[(A) $\frac{31}{37}$ of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$37 multiplied by the total number of recipients of aid to the permanently and totally disabled for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received aid to the permanently and totally disabled in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the permanently and totally disabled in the form of medical or any other type of remedial care); plus

[(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of \$75 multiplied by the total number of such recipients of aid to the permanently and totally disabled for such month; and

[(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$3.50 multiplied by the total number of recipients of aid to the permanently and totally disabled for such months; and

[(3) in the case of any State whose State plan approved under section 1402 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c) (1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled to help them attain or retain capability of self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c) (1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the permanently and totally disabled, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

[(C) one-half of the remainder of such expenditures.

[The services referred to in subparagraphs (A) and (B) shall except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administer-

ing or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

[(4) in the case of any State whose State plan approved under section 1402 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.

[(b) The method of computing and paying such amounts shall be as follows:

[(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other investigation as the Secretary may find necessary.

[(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan; except that such increases or reductions shall

not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

[(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, paid to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

[(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1402 must provide that the State agency shall make available to applicants for or recipients of aid to the permanently and totally disabled at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.

【Operations of State Plans

【Sec. 1404. In the case of any State plan for aid to the permanently and totally disabled which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

[(1) that the plan has been so changed as to impose any residence or citizenship requirements prohibited by section 1402(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

[(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1402 (a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until he is satisfied that such prohibited requirement is no longer so imposed and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[Definition

[Sec. 1405. For the purposes of this title, the term "aid to the permanently and totally disabled" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of, needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1402 includes provision for—

[(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

[(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

[(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

[(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

[(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.]

TITLE XV—GRANTS TO STATES FOR CARE AND TREATMENT OF DRUG ADDICTS AND ALCOHOLICS

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Purpose; Appropriation

Sec. 1501. For the purpose of enabling the States to furnish care and treatment to drug addicts and alcoholics to help such individuals to terminate their dysfunctional dependency on drugs or alcohol, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for care and treatment of such individuals.

SUBPART 1—STATE PLANS FOR CARE AND TREATMENT OF DRUG ADDICTS AND ALCOHOLICS

General Administrative Provisions

Sec. 1502. A State plan for care and treatment of medically determined drug addicts and alcoholics must—

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

(b) provide for financial participation by the State;

(c) either provide for the designation of a single State agency to administer the plan, or provide for the designation of a single State agency to supervise the administration of the plan;

(d) provide that the State agency designated to administer or supervise the administration of the plan will enter into an agreement with the appropriate State agencies designated under the

Comprehensive Alcohol Abuse and Treatment Act of 1970 and the Drug Abuse and Treatment Act of 1972 under which (1) such agencies will prepare and implement a rehabilitation plan for each individual enrolled in the care and treatment program and will certify to the State agency those local treatment agencies, organizations, institutions, and practitioners qualified to provide care and treatment under the State plan, and (2) the State agency will assume responsibility for financing the program, accept applications from individuals desiring to enroll in the program, determine eligibility, and certify the maximum amount any enrollee may receive for his maintenance;

(e) set forth the methods of administration to be followed in carrying out the State plan which—

(1) include methods relating to the establishment and maintenance of personnel standards on a merit basis, and

(2) provide for the training and effective use of paid sub-professional staff, with particular emphasis on the full-time or part-time employment of recipients of assistance, as community services aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and enrollees;

(f) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; and

(g) provide (1) that, as a condition of eligibility under the plan, each applicant or enrollee shall furnish to the State agency his social security account number (or numbers, if he has more than one such number), and (2) that such State agency shall utilize such account numbers, in addition to any other means of identification it may determine to employ, in the administration of such plan.

Determining Eligibility for Care and Treatment; Rehabilitation Plan

Sec. 1503. *A State plan for care and treatment of drug addicts and alcoholics must—*

(a) provide that any individual who (1) would be eligible, except for section 411(f)(6), for aid under the State plan approved under part A of title IV, or would be eligible for assistance under the State plan approved under title XIV or XVI, or, after December 31, 1973, would be eligible, except for section 1611(e)(3), for supplementary security income under title XVI, and (2) who is medically determined, by a physician qualified to make such a determination, to be unable to engage in any substantial gainful activity (or, in the case of a child under the age of 18, if he suffers from a physical or mental impairment of comparable severity) by reason of a medically determinable addictive dependency on drugs or alcohol which has lasted or can be expected to last for a period of 12 months, shall be eligible, upon applica-

tion, to enroll in the program of care and treatment established by the State under this title;

(b) provide that the appropriate agency (as determined under the agreement required by section 1502(d))—

(1) prepare a rehabilitation plan for each enrollee which will—

(A) provide for active care and treatment under a professionally developed plan of rehabilitation that is designed to terminate dysfunctional dependency on alcohol or drugs,

(B) include, to the extent appropriate, work experience, and

(C) include a determination of (i) the needs, if any, of such enrollee for maintenance payments and (ii) the amount of any such payment: Provided, That no such payment shall be in excess of the amount of aid such enrollee would be eligible to receive if he was eligible, except for section 411(f)(6), for aid under the State plan approved under part A of title IV, or if he was eligible for assistance under the State plan approved under title XIV or XVI, or, after December 31, 1973, if he was eligible, except for section 1611(e)(3), for supplementary security income under title XVI;

(2) make (in consultation with the State agency) arrangements for protective payments to be made on behalf of the enrollee to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such individual, or directly to a person furnishing food, living accommodations, or other goods, services, or items for such enrollee; and

(3) review the rehabilitation plan for each enrollee not less often than every three months, and, as a part of such review, determine whether protective payments should continue to be made and whether such payments should be made directly to such enrollee;

(c) make funds available for the provision of active care and treatment for individuals, pursuant to a rehabilitation plan prepared under subsection (b)(1), referred to local treatment agencies, organizations, institutions, or practitioners certified as qualified under section 1502(d);

(d) provide that all individuals enrolled in the treatment program established by the State under this title will be referred for care and treatment, pursuant to a rehabilitation plan prepared under subsection (b)(1), to a local treatment agency, organization, institution, or practitioner certified as qualified under section 1502(d);

(e) provide that any individual referred to the appropriate agency for care and treatment under the State plan or any enrollee under the plan who shall refuse such care and treatment, without good cause, shall be ineligible to receive further care and treatment under this title; and

(f) provide that in any case in which more or less than the correct amount of any payment for any month was paid to an

enrollee (or to another individual on behalf of an enrollee) under the plan,

(1) in the case of underpayments, proper adjustment shall be made in future payments with respect to such enrollee which are made within such maximum period of time as the State agency may prescribe, and

(2) in the case of overpayments—

(A) proper adjustment or recovery shall be made in future payments with respect to such enrollee or by recovery from such enrollee in accordance with procedures of the State for collection of overpayments, or

(B) if such adjustment or recovery cannot be made, the State agency will so notify the Secretary so that he may make appropriate adjustments to or recovery from other amounts which may be owed to such enrollee by the United States pursuant to section 1511.

Statutory Rights of Applicants and Enrollees

Sec. 1504. *A State plan for care and treatment of drug addicts and alcoholics must—*

(a) *provide for granting an opportunity for an evidentiary hearing before the State agency or, if the State plan is administered in each of the political subdivisions of the State by a local agency, before such local agency, to any individual (1) whose application for enrollment for care and treatment under the plan is denied or is not acted upon with reasonable promptness, or (2) who has been found ineligible for further care and treatment pursuant to section 1503(e); and*

(b) *provide safeguards which permit the use of disclosure of information concerning applicants or recipients only (1) to public officials who require such information in connection with their official duties, or (2) to other persons for purposes directly connected with the administration of the plan for care and treatment of drug addicts and alcoholics.*

SUBPART 2—PAYMENTS TO STATES

Payments to States

Sec. 1505. (a) *From the sums appropriated therefor, the Secretary shall pay to each State which has a plan for care and treatment of drug addicts and alcoholics approved under this title, for each quarter, beginning with the quarter commencing with the calendar year beginning January 1, 1973—*

(1) (A) *an amount equal to the amount such State would have been entitled to receive as reimbursement for payments to individuals under this title if such individuals had been receiving aid or assistance under (i) the State plan for aid to families with dependent children approved under part A of title IV, if such individual had been eligible to receive such aid except for the provisions of section 411(f)(6), or (ii) prior to January 1, 1974, the State plan approved under title XIV or XVI; and*

(B) an amount equal to the amount such individual would have received as supplementary security income under title XVI, if such individual had been eligible to receive such income except for the provisions of section 1611(e)(3);

(2) an amount equal to the Federal social service percentage (as defined in section 1101(a)(8)) of so much of such expenditures as are for social services authorized to be made available under sections 407(b) and 1607(b);

(3) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amounts expended during such quarter as medical assistance (as defined in section 1905(a) of this Act) under the State plan for care and treatment (including expenditures for premiums under part B of title XVIII, for individuals who were, at the time of their enrollment, recipients of money payments under a State plan approved under another title of this Act, or payments for foster care in accordance with section 406, and other insurance premiums for medical or any other type of remedial care or the cost thereof) and as reasonable payment for professional activities, other than the direct provision of services, performed in the administration of this title by skilled professional medical personnel and staff directly supporting such personnel pursuant to section 1902(a)(26) and (31), regardless of whether such activities are performed by State agency personnel or by others under an arrangement with such agency; and

(4) an amount equal to 50 per centum of the total amount expended during such quarter as are found necessary by the Secretary for the proper and efficient administration of the plan (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods of administration included in the State plan pursuant to section 1502(e)).

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimates of the total sum to be expended in such quarter in accordance with the other provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of individuals disabled (as that term is used in section 1503(a)(2)) by reason of addictive dependence upon alcohol or drugs in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably en-

titled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to payments made under the State plan but excluding any amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c) The level of expenditures for the program established by the State under this title in any fiscal year beginning after the fiscal year ending June 30, 1973, shall be reduced by that percentage which is equal to the percentage reduction, if any, of total Federal, State, and local government expenditures in such State in the immediately preceding two fiscal years for all other programs of care and treatment for drug addicts and alcoholics (exclusive of the program established by the State under this title).

SUBPART 3—FEDERAL RESPONSIBILITY

Operation of State Plans

Sec. 1507. (a) The Secretary shall approve any plan which meets the requirements of this title.

(b) If the Secretary, after reasonable notice and opportunity for a hearing to the State agency administering or supervising administration of the State plan approved under this title, finds that in the administration of the plan there is a failure to comply substantially with any such provision required by this title to be included in the plan, the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failures).

Recovery of Overpayments to Drug Addicts and Alcoholics

Sec. 1508. In any case in which a State agency has notified the Secretary that it cannot recover from an individual overpayments to drug addicts and alcoholics, and that payments (if any) made to such individual, subsequent to the determination of the overpayment, are insufficient to permit adjustments to recoup such overpayment, the Secretary shall recover the amount of such overpayment from any amounts (other than lump-sum death benefits payable under section 202(i)) otherwise due such individual or becoming due such individual from any officer or agency of the United States or under any Federal program. An appropriate portion of amounts recovered under the preceding sentence shall be credited to the State which made such overpayment.

TITLE XVI—[GRANTS TO STATES FOR AID TO THE
AGED, BLIND, OR DISABLED, OR FOR SUCH AID AND
MEDICAL ASSISTANCE FOR THE AGED] *SUPPLEMEN-
TAL SECURITY INCOME FOR THE AGED, BLIND, AND
DISABLED*

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[Appropriation

[Section 1601. For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of individuals who are 65 years of age or over and who are not recipients of aid to the aged, blind, or disabled but whose income and resources are insufficient to meet the costs of necessary medical services, and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-support or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for

aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged.

[State Plans for Aid to the Aged, Blind, or Disabled, or for Such Aid and Medical Assistance for the Aged

[Sec. 1602. (a) A State plan for aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged, must—

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

[(2) provide for financial participation by the State;

[(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

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

[(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

[(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

[(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

[(8) provide that all individuals wishing to make application for aid or assistance under the plan shall have opportunity to do so, and that such aid or assistance shall be furnished with reasonable promptness to all eligible individuals;

[(9) provide, if the plan includes aid or assistance to or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

[(10) provide a description of the services (if any) which the State agency makes available to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

[(11) provide that no aid or assistance will be furnished any individual under the plan with respect to any period with respect to which he is receiving assistance under the State plan approved under title I or aid under the State plan approved under part A of title IV or under title X or XIV;

[(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

[(13) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of aid or assistance under the plan;

[(14) provide that the State agency shall, in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

[(A) if such individual is blind, the State agency (i) shall disregard the first \$85 per month of earned income plus one-half of earned income in excess of \$85 per month, and (ii) shall, for a period not in excess of 12 months, and may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan,

[(B) if such individual is not blind but is permanently and totally disabled, (i) of the first \$80 per month of earned income, the State agency may disregard not more than the first \$20 thereof plus one-half of the remainder, and (ii) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation,

[(C) if such individual has attained age 65 and is neither blind nor permanently and totally disabled, of the first \$80 per month of earned income the State agency may disregard not more than the first \$20 thereof plus one-half of the remainder, and

[(D) the State agency may, before disregarding the amounts referred to above in this paragraph (14), disregard not more than \$7.50 of any income;

[(15) if the State plan includes medical assistance for the aged—

[(A) provide for inclusion of some institutional and some noninstitutional care and services;

[(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

[(C) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of such assistance to individuals who are residents of the State but are absent therefrom; and

[(D) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan;

[(16) if the State plan includes aid or assistance to or in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

[(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

[(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution;

[(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 1603(a) (4) (A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with

respect to such recipients and such patients will be effectively carried out; and

[(D) provide methods of determining the reasonable cost of institutional care for such patients; and

[(17) if the State plan includes aid or assistance to or in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases;

[Notwithstanding paragraph (3), if on January 1, 1962, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV, the State agency which administered or supervised the administration of such plan approved under title X may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged) which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title.

[(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid or assistance under the plan—

[(1) an age requirement of more than sixty-five years; or

[(2) any residence requirement which (A) in the case of applicants for aid to the aged, blind, or disabled excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for such aid and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

[(3) any citizenship requirement which excludes any citizen of the United States.

[In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950 were applicable on January 1, 1962, and to which the sentence of section 1002(b) following paragraph (2) thereof is applicable on the date on which its State plan for aid to the aged, blind or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged) was submitted for approval under this title, the Secretary shall approve the plan of such State for aid to the aged, blind, or disabled (or for aid to the aged, blind, or

disabled and medical assistance for the aged) for purposes of this title, even though it does not meet the requirements of paragraph (14) of subsection (a) if it meets all other requirements of this title for an approved plan for aid to the aged, blind, or disabled (or for aid to the aged, blind, or disabled and medical assistance for the aged); but payments under section 1603 shall be made, in the case any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1603 under a plan approved under this section without regard to the provisions of this sentence.

[(c) Subject to the last sentence of subsection (a), nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

[Payments to States

[Sec. 1603. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

[(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during each month of such quarter to the aged, blind, or disabled under the State plan (including expenditures for premiums under Part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

[(A) $\frac{31}{37}$ of such expenditures, not counting so much of any expenditure with respect to such month as exceeds the product of \$37 multiplied by the total number of recipients of such aid for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received such aid in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care); plus

[(B) the larger of the following:

[(i) (I) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess with respect to such month as exceeds the product of \$38 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month, plus (II) 15 per centum of the total expended during such month as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such month as exceeds the product of \$15 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month, or

[(ii) (I) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to such month as exceeds (a) the product of \$52 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (b) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of \$37 multiplied by such total number of such recipients plus (II) the Federal percentage of the amount by which the total expended during such month as aid to the aged, blind, or disabled under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B) (ii), not counting so much of such excess with respect to such month as exceeds the product of \$38 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month;

[(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

[(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

[(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of \$45 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (II) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of \$37.50 multiplied by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of \$7.50 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month;

[(3) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 61(c)) of the total amounts expended during such quarter as medical assistance for

the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof); and

[(4) in the case of any State whose State plan approved under section 1602 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence to applicants for or recipients of aid or assistance under the plan to help them attain or retain capability for self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid or assistance under the plan if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid or assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid or assistance;

[(C) one-half of the remainder of such expenditures. The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the adminis-

tration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

[except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and

[(5) in the case of any State whose State plan approved under section 1602 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.

[(b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

[(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

[(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered

during any quarter by the State or any political subdivision thereof with respect to aid or assistance furnished under the State plan, but excluding any amount of such aid or assistance recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under this subsection.

[(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[(c) (1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 1602 must provide that the State agency shall make available to applicants for or recipients of aid to the aged, blind, or disabled under such State plan at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency, administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision,

[(the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.

[(d) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures in the State from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis

of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.

【Operation of State Plans

【Sec. 1604. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

【(1) that the plan has been so changed that it no longer complies with the provisions of section 1602; or

【(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

【the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

【Definitions

【Sec. 1605. (a) For purposes of this title, the term “aid to the aged, blind, or disabled” means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

【(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

【(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

【Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

【(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

【(B) making such payments only in cases in which such pay-

ments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

[(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

[(D) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justify such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

[(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

[(b) For purposes of this title, the term "medical assistance for the aged" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals who are sixty-five years of age or older and who are not recipients of aid to the aged, blind, or disabled except, for any month, for recipients of aid to the aged, blind, or disabled who are admitted to or discharged from a medical institution during such month) but whose income and resources are insufficient to meet all of such cost—

- [(1) inpatient hospital services;
- [(2) skilled nursing-home services;
- [(3) physicians' services;
- [(4) outpatient hospital or clinic services;
- [(5) home health care services;
- [(6) private duty nursing services;
- [(7) physical therapy and related services;
- [(8) dental services;
- [(9) laboratory and X-ray services;
- [(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;

[(11) diagnostic, screening, and preventive services; and

[(12) any other medical care or remedial care recognized under State law;

except that such term does not include any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).]

Purpose; Appropriations

Sec. 1601. *For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this title.*

Basic Eligibility for Benefits

Sec. 1602. *Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Secretary of Health, Education, and Welfare.*

PART A—*Determination of Benefits*

Eligibility for and Amount of Benefits

Definition of Eligible Individual

Sec. 1611. (a) (1) *Each aged, blind, or disabled individual who does not have an eligible spouse and—*

(A) *whose income, other than income excluded pursuant to section 1612(b), is at a rate of not more than \$1,560 for the calendar year 1974 or any calendar year thereafter, and*

(B) *whose resources, other than resources excluded pursuant to section 1613(a) are not more than \$2,500,*
shall be an eligible individual for purposes of this title.

(2) *Each aged, blind, or disabled individual who has an eligible spouse and—*

(A) *whose income (together with the income of such spouse), other than income excluded pursuant to section 1612(b), is at a rate of not more than \$2,340 for the calendar year 1974, or any calendar year thereafter, and*

(B) *whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1613(a), are not more than \$2,500,*
shall be an eligible individual for purposes of this title.

Amount of Benefits

(b) (1) *The benefits under this title for an individual who does not have an eligible spouse shall be payable at the rate of \$1,560 for the calendar year 1974 and any calendar year thereafter, reduced by*

the amount of income, not excluded pursuant to section 1612(b), of such individual.

(2) The benefit under this title for an individual who has an eligible spouse shall be payable at the rate of \$2,340 for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, nor excluded pursuant to section 1612(b), of such individual and spouse.

Period for Determination of Benefits

(c)(1) An individual's eligibility for benefits under this title and the amount of such benefits shall be determined for each quarter of a calendar year except that, if the initial application for benefits is filed in the second or third month of a calendar quarter, such determinations shall be made for each month in such quarter. Eligibility for and the amount of such benefits for any quarter shall be redetermined at such time or times as may be provided by the Secretary.

(2) For purposes of this subsection an application shall be considered to be effective as of the first day of the month in which it was actually filed.

Special Limits on Gross Income

(d) The Secretary may prescribe the circumstances under which, consistently with the purposes of this title, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this title. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954.

Limitation on Eligibility of Certain Individuals

(e)(1)(A) Except as provided in subparagraph (B), no person shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, the benefit under this title for such individual for such month shall be payable—

(i) at a rate not in excess of \$300 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who does not have an eligible spouse;

(ii) at a rate not in excess of the sum of the applicable rate specified in subsection (b)(1) and the rate of \$300 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home, or facility throughout such month; and

(iii) at a rate not in excess of \$600 per year (reduced by the

amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who has an eligible spouse, if both of them are in such a hospital, home, or facility throughout such month.

(2) No person shall be an eligible individual or eligible spouse for purposes of this title if, after notice to such person by the Secretary that it is likely that such person is eligible for any payments of the type enumerated in section 1612(a)(2)(B), such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3) (A) No person who is under the age of 65, is not blind, and is medically determined to be a drug addict or an alcoholic, shall be an eligible individual or eligible spouse for purposes of this title.

(B) The Secretary shall refer to the State or appropriate local agency administering the plan of such State approved under title XV any individual described in subparagraph (A) who—

- (i) is applying for or receiving benefits under this title, and
- (ii) would be eligible for such benefits but for the provisions of such subparagraph (A).

(4) No person shall be an eligible individual or an eligible spouse for purposes of this title if, within one year immediately preceding his application for benefits under this title, he disposed of property (of any type) to a relative for less than fair market value, if the retention by him of such property would have caused him to be found ineligible for benefits under this title.

Suspension of Payments to Individuals Who Are Outside the United States

(f) Notwithstanding any other provision of this title, no individual shall be considered an eligible individual for purposes of this title for any month during all of which such individual is outside the United States (and no person shall be considered the eligible spouse of an individual for purposes of this title with respect to any month during all of which such person is outside the United States). For purposes of the preceding sentence, after an individual has been outside the United States for any period of 30 consecutive days, he shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days.

Income

Meaning of Income

Sec. 1612. (a) For purposes of this title, income means both earned income and unearned income; and—

(1) earned income means only—

(A) wages as determined under section 203(f)(5)(C); and

(B) net earnings from self-employment, as defined in section 211 (without the application of the second and third sentences following subsection (a)(10), and the last paragraph

- of subsection (a)), including earnings for services described in paragraphs (4), (5), and (6) of subsection (c); and
- (2) unearned income means all other income, including—
- (A) support and maintenance furnished in cash or kind; except that in the case of any individual (and his eligible spouse, if any) living in another person's household and receiving support and maintenance in kind from such person, the dollar amounts otherwise applicable to such individual (and spouse) as specified in subsections (a) and (b) of section 1611 shall be reduced by $3\frac{1}{3}$ percent in lieu of including such support and maintenance in the unearned income of such individual (and spouse) as otherwise required by this subparagraph;
 - (B) any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;
 - (C) prizes and awards;
 - (D) the proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial or \$1,500, whichever is less;
 - (E) gifts (cash or otherwise), support and alimony payments, and inheritances; and
 - (F) rents, dividends, interest, and royalties.

Exclusions From Income

- (b) In determining the income of an individual (and his eligible spouse) there shall be excluded—
- (1) subject to limitations (as to amount or otherwise) prescribed by the Secretary, if such individual is a child who is, 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, the earned income of such individual;
 - (2) the first \$600 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual;
 - (3) (A) the total unearned income of such individual (and such spouse, if any) in a calendar quarter which, as determined in accordance with criteria prescribed by the Secretary, is received too infrequently or irregularly to be included, if such income so received does not exceed \$60 in such quarter, and (B) the total earned income of such individual (and such spouse, if any) in a calendar quarter which, as determined in accordance with such criteria, is received too infrequently or irregularly to be included, if such income so received does not exceed \$30 in such quarter;

(4) (A) if such individual (or such spouse) is blind (and has not attained age 65, or received benefits under this title (or aid under a State plan approved under section 1002 or 1602) for the month before the month in which he attained age 65), (i) the first \$1,020 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof, (ii) an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan,

(B) if such individual (or such spouse) is disabled but not blind (and has not attained 65, or received benefits under this title (or aid under a State plan approved under section 1402 or 1602) for the month before the month in which he attained age 65), (i) the first \$1,020 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof, and (ii) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan, or

(C) if such individual (or such spouse) has attained age 65 and is not included under subparagraph (A) or (B), the first \$1,020 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof:

(5) any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased by such individual (or such spouse);

(6) assistance described in section 1616(a) which is based on need and furnished by any State or political subdivision of a State;

(7) any portion of any grant, scholarship, or fellowship received for use in paying the cost of tuition and fees at any educational (including technical or vocational education) institution;

(8) home produce of such individual (or spouse) utilized by the household for its own consumption;

(9) if such individual is a child one-third of any payment for his support received from an absent parent; and

(10) any amounts received for the foster care of a child who is not an eligible individual but who is living in the same home as such individual and was placed in such home by a public or non-profit private child-placement or child-care agency.

Resources

Exclusions From Resources

Sec. 1613. (a) In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

(1) the home (including the land that appertains thereto), to

the extent that its value does not exceed such amount as the Secretary determines to be reasonable;

(2) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Secretary determines to be reasonable;

(3) other property which, as determined in accordance with and subject to limitations prescribed by the Secretary, is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion; and

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan.

In determining the resources of an individual (or eligible spouse) an insurance policy shall 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 shall be taken into account.

Disposition of Resources

(b) The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

Meaning of Terms

Aged, Blind, or Disabled Individual

Sec. 1614. *(a) (1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—*

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence.

(2) An individual shall be considered to be blind for purposes of this title if he has 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 shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this title if he is blind as defined under a State plan approved under title X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3) (A) *An individual shall be considered to be disabled for purposes of this title 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. An individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973, so long as he is continuously disabled as so defined.*

(B) *For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity 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. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.*

(C) *For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.*

(D) *The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria, except for purposes of paragraph (4), shall be found not to be disabled.*

(4) (A) *For purposes of this title, any services rendered during a period of trial work (as defined in subparagraph (B)) by an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection) shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. As used in this paragraph, the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.*

(B) *The term "period of trial", with respect to an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection), means a period of months beginning and ending as provided in subparagraphs (C) and (D).*

(C) *A period of trial work for any individual shall begin with the month in which he becomes eligible for benefits under this title on the basis of his disability; but no such period may begin for an individual*

who is eligible for benefits under this title on the basis of a disability if he has had a previous period of trial work while eligible for benefits on the basis of the same disability.

(D) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(i) the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

(ii) the month in which his disability (as determined under paragraph (3) of this subsection) ceases (as determined after the application of subparagraph (A) of this paragraph).

Eligible Spouse

(b) For purposes of this title, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months. If two aged, blind, or disabled individuals are husband and wife as described in the preceding sentence, only one of them may be an "eligible individual" within the meaning of section 1611 (a).

Definition of Child

(c) For purposes of this title, the term "child" means an individual who is neither married nor (as determined by the Secretary) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-one 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

(d) In determining whether two individuals are husband and wife for purposes of this title, appropriate State law shall be applied; except that—

(1) if a man and woman have been determined to be husband and wife under section 216(h)(1) for purposes of title II they shall be considered (from and after the date of such determination or the date of their application for benefits under this title, whichever is later) to be husband and wife for purposes of this title, or

(2) if a man and woman are found to be holding themselves out to the community in which they reside as husband and wife, they shall be so considered for purposes of this title notwithstanding any other provision of this section.

United States

(e) For purposes of this title, the term "United States", when used in a geographical sense, means the 50 States and the District of Columbia.

Income and resources of individuals other than eligible individuals and eligible spouses

(f) (1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

(2) For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 21, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

Rehabilitation Services for Blind and Disabled Individuals

Sec. 1615. (a) In the case of any blind or disabled individual who—

(1) has not attained age 65, and

(2) is receiving benefits (or with respect to whom benefits are paid) under this title,

the Secretary shall make provision for referral of such individual to the appropriate State agency administering the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act, and (except in such cases as he may determine) for a review not less often than quarterly of such individual's blindness or disability and his need for and utilization of the rehabilitation services made available to him under such plan.

(b) Every individual with respect to whom the Secretary is required to make provision for referral under subsection (a) shall accept such rehabilitation services as are made available to him under the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act; and the Secretary is authorized to pay to the State agency administering or supervising the administration of such State plan the costs incurred in the provision of such services to individuals so referred.

(c) No individual shall be an eligible individual or eligible spouse for purposes of this title if he refuses without good cause to accept vocational rehabilitation services for which he is referred under subsection (a).

Optional State Supplementation

Sec. 1616. (a) Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this title or who would but for their income be eligible to receive benefits under this title, as assistance based on need in supplementation of such benefits (as determined by the Secretary), shall be excluded under section 1612(b)(6) in determining the income of such individuals for purposes of this title and the Sec-

retary and such State may enter into an agreement which satisfies subsection (b) under which the Secretary will, on behalf of such State (or subdivision), make such supplementary payments to all such individuals.

(b) Any agreement between the Secretary and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this title, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Secretary finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which he conducts under this title and the optional State supplementation.

(c) Any State (or political subdivision) making supplementary payments described in subsection (a) may at its option impose as a condition of eligibility for such payments, and include in the State's agreement with the Secretary under such subsection, a residence requirement which excludes individuals who have resided in the State (or political subdivision) for less than a minimum period prior to application for such payments.

(d) Any State which has entered into an agreement with the Secretary under this section which provides that the Secretary will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this title (or who would but for their income be eligible to receive such benefits), shall, at such times and in such installments as may be agreed upon between the Secretary and such State, pay to the Secretary an amount equal to the expenditures made by the Secretary as such supplementary payments.

PART B—Procedural and General Provisions

Payments and Procedures

Payment of Benefits

Sec. 1631. (a) (1) Benefits under this title shall be paid at such time or times and in such installments as will best effectuate the purposes of this title, as determined under regulations (and may in any case be paid less frequently than monthly where the amount of the monthly benefit would not exceed \$10).

(2) Payments of the benefit of any individual may be made to any such individual or to his eligible spouse (if any) or partly to each, or, if the Secretary deems it appropriate to any other person (including an appropriate public or private agency) who is interested in or concerned with the welfare of such individual (or spouse).

(3) The Secretary may by regulation establish ranges of incomes within which a single amount of benefits under this title shall apply.

(4) The Secretary—

(A) may make to any individual initially applying for benefits under this title who is presumptively eligible for such benefits

and who is faced with financial emergency a cash advance against such benefits in an amount not exceeding \$100; and

(B) may pay benefits under this title to an individual applying for such benefits on the basis of disability for a period not exceeding 3 months prior to the determination of such individual's disability, if such individual is presumptively disabled and is determined to be otherwise eligible for such benefits, and any benefits so paid prior to such determination shall in no event be considered overpayments for purposes of subsection (b).

(5) Payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), and who ceases to be blind or to be under such disability, shall continue (so long as such individual is otherwise eligible) through the second month following the month in which such blindness or disability ceases.

Overpayments and Underpayments

(b) Whenever the Secretary finds that more or less than the correct amount of benefits has been paid with respect to any individual, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments to such individual or by recovery from or payment to such individual or his eligible spouse (or by recovery from the estate of either). The Secretary shall make such provision as he finds appropriate in the case of payment of more than the correct amount of benefits with respect to an individual with a view to avoiding penalizing such individual or his eligible spouse who was without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this title, or be against equity or good conscience, or (because of the small amount involved) impede efficient or effective administration of this title.

Hearings and Review

(c) (1) The Secretary shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be an eligible individual or eligible spouse and is in disagreement with any determination under this title with respect to eligibility of such individual for benefits, or the amount of such individual's benefits, if such individual requests a hearing on the matter in disagreement within thirty days after notice of such determination is received.

(2) Determination on the basis of such hearing, except to the extent that the matter in disagreement involves the existence of a disability (within the meaning of section 1614(a)(3)), shall be made within ninety days after the individual requests the hearing as provided in paragraph (1).

(3) The final determination of the Secretary after a hearing under paragraph (1) shall be subject to judicial review as provided in section 205(g) to the same extent as the Secretary's final determinations

under section 205; except that the determination of the Secretary after such hearing as to any fact shall be final and conclusive and not subject to review by any court.

Procedures; Prohibitions of Assignments; Representation of Claimants

(d) (1) *The provisions of section 207 and subsections (a), (d), (e), and (f) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.*

(2) *To the extent the Secretary finds it will promote the achievement of the objectives of this title, qualified persons may be appointed to serve as hearing examiners in hearings under subsection (c) without meeting the specific standards prescribed for hearing examiners by or under subchapter II of chapter 5 of title 5, United States Code.*

(3) *The Secretary may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys, as hereinafter provided, representing claimants before the Secretary under this title, and may require of such agents or other persons, before being recognized as representatives of claimants, that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Secretary. The Secretary may, after due notice and opportunity for hearing, suspend or prohibit from further practice before him any such person, agent, or attorney who refuses to comply with the Secretary's rules and regulations or who violates any provision of this paragraph for which a penalty is prescribed. The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Secretary under this title, and any agreement in violation of such rules and regulations shall be void. Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter, or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Secretary, shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding \$500 or by imprisonment not exceeding one year, or both.*

Applications and Furnishing of Information

(e) (1) (A) *The Secretary shall, subject to subparagraph (B), prescribe such requirements 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 may be necessary for the effective and efficient administration of this title.

(B) The requirements prescribed by the Secretary pursuant to subparagraph (A) shall require that eligibility for benefits under this title will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified to the maximum extent feasible from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct.

(2) In case of the failure by any individual to submit a report of events and changes in circumstances relevant to eligibility for or amount of benefits under this title as required by the Secretary under paragraph (1), or delay by any individual in submitting a report as so required, the Secretary (in addition to taking any other action he may consider appropriate under paragraph (1)) shall reduce any benefits which may subsequently become payable to such individual under this title by—

(A) \$25 in the case of the first such failure or delay,

(B) \$50 in the case of the second such failure or delay, and

(C) \$100 in the case of the third or a subsequent such failure or delay,

except where the individual was without fault or good cause for such failure or delay existed.

Furnishing of Information by Other Agencies

(f) The head of any Federal agency shall provide such information as the Secretary needs for purposes of determining eligibility for or amount of benefits, or verifying other information with respect thereto.

Penalties for Fraud

Sec. 1632. Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit under this title.

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit, or (B) the initial or continued right to any such benefit of any other individual in whose behalf he has applied for or is receiving such benefit, conceals or fails to disclose such event with an intent fraudulently to secure such benefit either in a greater amount or quantity than is due or when no such benefit is authorized, or

(4) having made application to receive any such benefit for the use and benefit of another and having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000 or imprisoned for not more than one year, or both.

Administration

Sec. 1633. The Secretary may make such an administrative and other arrangements (including arrangements for the determination of blindness and disability under section 1614(a)(2) and (3) in the same manner and subject to the same conditions as provided with respect to disability determinations under section 221) as may be necessary or appropriate to carry out his functions under this title.

Determinations of Medicaid Eligibility

Sec. 1634. The Secretary may enter into an agreement with any State which wishes to do so under which he will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under title XIX. Any such agreement shall provide for payments by the State, for use by the Secretary in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this title, the Secretary shall include only those costs which are additional to the costs incurred in carrying out this title.

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Prohibition Against Any Federal Interference

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

Free Choice by Patient Guaranteed

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

Option to Individuals To Obtain Other Health Insurance Protection

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

Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

Sec. 1811. The insurance program for which entitlement is established by section 226 provides basic protection against the costs of hospital and related post-hospital services and eligible drugs in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system and (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits

under title II of this Act or under the railroad retirement system on the basis of a disability.

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d) (2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

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

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

(4) *eligible drugs.*

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

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

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

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

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b) (1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b) (3)).

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

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

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

Deductibles and Coinsurance

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

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

(B) **[one-half]** *one-fourth* of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a) (1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;¹

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

¹ Applies with respect to inpatient hospital services furnished during spells of illness beginning after December 31, 1972.

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

(4) *The reasonable allowance, as defined in section 1823, for eligible drugs furnished an individual pursuant to any one prescription (or each renewal thereof) and purchased by such individual at any one time shall be reduced by an amount equal to the applicable prescription copayment obligation which shall be \$1.*

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

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

(c) *The prescription copayment which shall be applicable for the purposes of subsection (a) (4) shall be \$1 and so much of the cost of such prescription (in the case of a drug product prescribed by a physician, of a drug entity included in the formulary where the cost of such product exceeds the maximum medicare allowance) as is in excess of the maximum medicare allowance established for such drug entity in accordance with section 1823.*

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) **[**Except as provided in subsection (d)**]** *Except as provided in subsections (d) and (g)¹ and in section 1876,² payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—*

(1) written request, signed by such individual, except in cases

¹ Applies to accounting periods beginning after December 31, 1972.

² Effective with respect to services provided on or after July 1, 1973.

in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

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

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

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

[(C) in the case of post-hospital extended care services, such services are or were required to be given on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services]

(C) *in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services,*¹ (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) [and (8)] and (9)² of section 1861(e)) prior to transfer to the [extended care facility]

¹ Applies with respect to services furnished after December 31, 1972.

² Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services; **or**

(D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) **and (8)** and (9)¹ of 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(E) *in the case of inpatient hospital services in connection with a dental procedure, the individual suffers from impairments of such severity as to require hospitalization;*²

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

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

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

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as

¹Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

²Applies to admissions occurring after the second month following the month of enactment.

may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or **[extended care facility]** *skilled nursing facility*, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); **[and]**

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, **[as described in section 1861(k)(4)]** *as described in section 1861(k)(4)*, including any finding made in the course of a sample or other review of admissions to the institution)¹ pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or **[extended care facility]** *skilled nursing facility*, as the case may be, received notice of such finding**[.]**; and

(8) *with respect to drugs or biologicals furnished pursuant to and requiring (except for insulin) a physician's prescription, such drugs or biologicals are eligible drugs as defined in section 1861(t) and the participating pharmacy (as defined in section 1861(dd)) has such prescription in its possession, or some other record (in the case of insulin) that is satisfactory to the Secretary.*²

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

[Reasonable Cost of Services] Amount Paid to Providers³

(b) (1) The amount paid to any provider of services (*other than a pharmacy*) with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—**[the reasonable cost of such services, as determined under section 1861(v)]**

(A) *the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or*

(B) *if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations*

¹ Applies to services furnished after the second month following the month of enactment.

² Applies with respect to eligible drugs furnished on and after July 1, 1973.

³ Applies to services furnished by hospitals, skilled nursing facilities, and home health agencies in accounting periods beginning after December 31, 1972.

prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.

(2) The amount paid to any participating pharmacy which is a provider of services with respect to eligible drugs for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable allowance (as defined in section 1823) with respect to such drugs.

No Payments to Federal Providers of Services

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

Payments for Emergency Hospital Services

(d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement

may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

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

[Payment for Certain Emergency Hospital Services Furnished Outside the United States] *Payment for Certain Inpatient Hospital Services Furnished Outside the United States*¹

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

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

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

(f) (1) *Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—*

(A) *such individual is a resident of the United States; and*

(B) *such hospital was closer to, or substantially more accessible*

¹ Applies to services furnished with respect to admissions occurring after December 31, 1972.

from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

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

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d) (3).

Payment for Services of a Physician Rendered in a Teaching Hospital¹

(g) For purposes of services for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

¹ Applies to accounting periods after December 31, 1972.

(1) *such hospital has an agreement with the Secretary under section 1866, and*

(2) *the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).*

Payment for Posthospital Extended Care Services¹

(h)(1) *An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to a skilled nursing facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—*

(A) *the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such skilled nursing facility,*

(B) *such certification states that the medical condition of the individual is a condition designated in regulations,*

(C) *such certification is accompanied by a plan of treatment for providing such services, and*

(D) *there is compliance with such other requirements and procedures as may be specified in regulations,*

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

(2) *If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).*

Payment for Posthospital Home Health Services²

(i)(1) *An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—*

(A) *the certification and plan referred to in subsection (a)*

¹ Applies to admissions to skilled nursing facilities initiated on or after January 1, 1973.
² Applies to home health plans initiated on or after January 1, 1973.

(2) (D) of this section are submitted in timely fashion prior to the first visit by such agency,

(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

(C) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).

Limitation on Payment for Eligible Drugs¹

(j) Payment may be made under this part for eligible drugs only when such drugs are dispensed by a participating pharmacy; except that payment under this part may be made for eligible drugs dispensed by a physician where the Secretary determines, in accordance with regulations, that such eligible drugs were required in an emergency or that there was no participating pharmacy available in the community, in which case the physician (under regulations prescribed by the Secretary) shall be regarded as a participating pharmacy for purposes of this part with respect to the dispensing of such eligible drugs.

Payment to Providers of Services

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

¹ Applies with respect to eligible drugs furnished on and after July 1, 1973.

Use of Public Agencies or Private Organizations To Facilitate Payment to Providers of Services

Sec. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to¹ *subject to the provisions of section 1878 and to* such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

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

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

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may,

¹ Applies to cost reports of providers of services, as defined in title XVIII of the Act, for accounting periods ending on or after June 30, 1973.

upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.】

(d) *Effective January 1, 1973, the Secretary is authorized to assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section whenever he determines, in his sole discretion, that to do so would result in more effective and efficient administration of this part. In making any such assignment or reassignment the Secretary shall take into consideration the choice of any such provider, but he shall not be bound by such choice.*

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

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

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

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

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

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

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

Federal Hospital Insurance Trust Fund

Sec. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hos-

pital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of *such gifts and bequests as may be made as provided in section 201(i)(1), and*¹ such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

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

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

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

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

- (1) Hold the Trust Fund;
- (2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund dur-

¹ Applies to gifts and bequests received after the date of enactment.

ing the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

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

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

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

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

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

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

(f) (1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him

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

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

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

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

***Hospital Insurance Benefits for Uninsured Individuals Not
Otherwise Eligible***

Sec. 1818. (a) *Every individual who—*

(1) *has attained the age of 65,*

(2) *is enrolled under part B of this title,*

(3) *is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and*

(4) *is not otherwise entitled to benefits under this part,*

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

(b) *An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.*

(c) *The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (c) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—*

(1) *individuals who meet the conditions of subsection (a) (1), (3), and (4) on or before the last day of the seventh month after the month in which this section is enacted may enroll under this part and (if not already so enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after the date on which this section is enacted and shall end on the last day of the tenth month after the month in which this Act is enacted;*

(2) *in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after the month in which this section is enacted, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;*

(3) *in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—*

(A) *the first day of the second month after the month in which he enrolls,*

(B) *July 1, 1973, or*

(C) *the first day of the first month in which he meets the requirements of subsection (a), whichever is the latest;*

(4) *termination of coverage under this section by the filing of notice that the individual no longer wishes to participate in the hospital insurance program shall take effect at the close of the month following the month in which such notice is filed;*

(5) *an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement; and*

(6) *termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act.*

(d) (1) *The monthly premium of each individual for each month in his coverage period before July 1974 shall be \$33.*

(2) *The Secretary shall, during the last calendar quarter of each year, beginning in 1973, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months*

occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to \$33, multiplied by the ratio of (A) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest multiple of \$1, or if midway between multiples of \$1 to the next higher multiple of \$1.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

Hospital Insurance for Individuals, Age 60 Through 64, Who Are Entitled to Benefits Under Section 202 or Who Are Spouses of Individuals Entitled to Health Insurance

Sec. 1819. (a) Every individual who—

(1) has attained the age of 60, but has not attained the age of 65; and

(2) is either—

(A) an individual entitled to monthly insurance benefits under section 202 or benefits under the Railroad Retirement Act of 1937, or

(B) the wife or husband of a person entitled to benefits under this part, or

(C) an individual entitled to benefits under—

(i) section 223(a), or

(ii) subsections (d), (e), (f), or (x), of section 202 based on disability,

but who has not met the conditions of section 226(a)(2)(B); and

(3) is enrolled under part B of this title shall be eligible to enroll in the insurance program established by this part.

(b)(1) An individual may enroll only once under this section and only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) In the case of an individual who satisfies paragraph (1) of subsection (a) of this section and either subparagraph (A) or subparagraph (C) of paragraph (2) of such subsection, his enrollment period shall begin with whichever of the following is the latest:

(A) April 1, 1973, or

(B) the date such individual first meets the conditions in such paragraph (2), or

(C) the date the Secretary sends notice to such individual that he is entitled to any monthly insurance benefits as specified in subparagraph (A) or subparagraph (C) of such paragraph (2) and shall end at the close of the—

(D) 90th day thereafter, if such enrollment period begins on the date specified in subparagraphs (B) or (C) of this paragraph, or

(E) the 180th day thereafter, if such enrollment period begins on April 1, 1973.

(3) In the case of an individual satisfying paragraph (1) and paragraph (2)(B) of subsection (a) of this section, his enrollment period shall begin on whichever of the following is the later: (A) April 1, 1973, or (B) the date such individual first meets the conditions specified in such paragraphs, and shall end at the close of the (C) 90th day thereafter, if such enrollment period begins on the date specified in clause (B) of this paragraph or (D) the 180th day thereafter, if such enrollment period begins on April 1, 1973.

(c) (1) In the case of an individual who enrolls pursuant to the provisions of this section, the coverage period during which he is entitled to benefits under this part shall begin on the first day of the second month after the month in which he enrolls, or July 1, 1973, whichever is later.

(2) An individual's coverage period shall terminate at the earliest of the following—

(A) for failure to make timely premium payments, at such time as may be prescribed in regulations which may include a grace period in which overdue premiums may be paid and coverage continued, but such grace period shall not exceed 30 days, except that it may be extended to not to exceed 60 days in any case where the Secretary determines that there was good cause for failure to pay overdue premiums within such 30-day period; or

(B) at the close of the month following the month in which an individual files a notice with the Secretary that he no longer desires to be enrolled under this section; or

(C) with the month before the month he no longer meets the conditions specified in subsection (a).

Notwithstanding the preceding provisions of this paragraph, an individual's coverage period shall terminate with the month before the first month in which such individual becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such month the application required to establish such entitlement.

(d) (1) The monthly premium of each individual under this section for each month in his coverage period before July 1974 shall be \$33.

(2) The Secretary shall, during December of 1973 and of each year thereafter, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums chargeable to individuals for months occurring in the 12-month period commencing July 1 of the next succeeding year. Such amount shall be actuarially adequate on a per capita basis to meet the estimated amounts of incurred claims and administrative expenses for individuals enrolled under this section during such period; and such amount shall take into consideration underwriting losses or gains incurred during prior

years. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest \$1, or if midway between multiples of \$1, to the next higher multiple of \$1.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or other arrangement is administratively feasible.

(f) (1) The provisions of section 1840 shall apply to individuals enrolled under this section if such individuals are entitled to monthly insurance benefits under section 202 or 223. The provisions of subsections (e), (f), (g), and (h) of such section 1840 shall apply to any other individuals so enrolled.

(2) Where an individual enrolled under this section meets the provisions of paragraph (2) (B) of subsection (a) (but does not meet the provisions of paragraph (2) (A) or (2) (C) of such subsection) and the person referred to in such paragraph (2) (B) is entitled to monthly insurance benefits under section 202 or section 223, the provisions of section 1840(a) (1) shall apply to such benefits as though such husband or wife were entitled to such benefits, unless such person files a notice with the Secretary that the deductions provisions of such section 1840(a) (1) shall not apply.

(g) The term "wife" or "husband" as used in this section shall have the meaning assigned to those terms by subsection (b) and subsection (f) of section 216, as the case may be, except that the provisions of clause (2) of such subsection (b) and clause (2) of such subsection (f) shall not apply.

Medicare Formulary Committee¹

Sec. 1820. (a) (1) There is hereby established, within the Department of Health, Education, and Welfare, a Medicare Formulary Committee (hereinafter referred to as the "Committee"), a majority of whose members shall be physicians and which shall consist of the Commissioner of Food and Drugs and of four individuals (not otherwise in the employ of the Federal Government) who do not have a direct or indirect financial interest in the composition of the Formulary established under this section and who are of recognized professional standing and distinction in the fields of medicine, pharmacology, or pharmacy, to be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Chairman of the Committee shall be elected annually from the appointed members thereof, by majority vote of the members of the Committee.

(2) Each appointed member of the Committee shall hold office for a term of five years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall

¹ Applies with respect to eligible drugs furnished on and after July 1, 1973.

expire, as designated by the Secretary at the time of appointment, one at the end of each of the first five years. A member shall not be eligible to serve continuously for more than two terms.

(b) Appointed members of the Committee, while attending meetings or conferences thereof or otherwise serving on business of the Committee, shall be entitled to receive compensation at rates fixed by the Secretary (but not in excess of the daily rate paid under GS-18 of the General Schedule under section 5332 of title 5, United States Code), including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

(c) (1) The Committee is authorized, with the approval of the Secretary, to engage or contract for such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Committee such secretarial, clerical, and other assistance as the Formulary Committee may require to carry out its functions.

(2) The Secretary shall furnish to the Committee such office space, materials, and equipment as may be necessary for the Formulary Committee to carry out its functions.

Medicare Formulary ¹

Sec. 1821. *(a) (1) The Committee shall compile, publish, and make available a Medicare Formulary (hereinafter in this title referred to as the "Formulary").*

(2) The Committee shall periodically revise the Formulary and the listing of drugs so as to maintain currency in the contents thereof.

(b) (1) The Formulary shall contain an alphabetically arranged listing, by established name, of those drug entities within the following therapeutic categories:

- Adrenocorticoids*
- Anti-anginals*
- Anti-arrhythmics*
- Anti-coagulants*
- Anti-convulsants (excluding phenobarbital)*
- Anti-hypertensives*
- Anti-neoplastics*
- Anti-rheumatics*
- Anti-Parkinsonism agents*
- Bronchodilators*
- Cardiotonics*
- Cholinesterase inhibitors*
- Diuretics*
- Gout suppressants*
- Hypoglycemics*
- Miotics*
- Thyroid hormones*
- Tuberculostatics*

¹ Applies with respect to eligible drugs furnished on and after July 1, 1973.

which the Committee decides are necessary for individuals using such drugs. The Committee shall exclude from the Formulary any drug entities (or dosage forms and strengths thereof) which the Committee decides are not necessary for proper patient care, taking into account other drug entities (or dosage forms and strengths thereof) which are included in the Formulary.

(2) Such listing shall include the specific dosage forms and strengths of each drug entity (included in the Formulary in accordance with paragraph (1)) which the Committee decides are necessary for individuals using such drugs.

(3) Such listing shall include the prices at which the products (in the same dosage form and strength) of such drug entities are generally sold by the suppliers thereof and the limit applicable to such prices under section 1823(b)(1) for purposes of determining the reasonable allowance.

(4) The Committee may also include in the Formulary, either as a separate part (or parts) thereof or as a supplement (or supplements) thereto, any or all of the following information:

(A) A supplementary list or lists, arranged by diagnostic, prophylactic, therapeutic, or other classifications, of the drug entities (and dosage forms and strengths thereof) included in the listing referred to in paragraph (1).

(B) The proprietary names under which products of a drug entity listed in the Formulary by established name (and dosage form and strength) are sold and the names of each supplier thereof.

(C) Any other information with respect to eligible drug entities which in the judgment of the Committee would be useful in carrying out the purposes of this part.

(c) In considering whether a particular drug entity (or strength or dosage form thereof) shall be included in or excluded from the Formulary, the Committee is authorized to obtain (upon request therefor) any record pertaining to the characteristics of such drug entity which is available to any other department, agency, or instrumentality of the Federal Government, and to request suppliers or manufacturers of drugs and other knowledgeable persons or organizations to make available to the Committee information relating to such drug. If any such record or information (or any information contained in such record) is of a confidential nature, the Committee shall respect the confidentiality of such record or information and shall limit its usage thereof to the proper exercise of its authority.

(d)(1) The Committee shall establish such procedures as it determines to be necessary in its evaluation of the appropriateness of the inclusion in or exclusion from the Formulary, of any drug entity (or dosage form or strength thereof). For purposes of inclusion in or exclusion from the Formulary the principal factors in the determination of the Committee shall be:

(A) the factor of clinical equivalence in the case of the same dosage forms in the same strengths of the same drug entity, and

(B) the factor of relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category.

(2) The Committee, prior to making a final decision to remove from

listing in the Formulary any drug entity (or dosage forms or strengths thereof) which is included therein, shall afford a reasonable opportunity for a formal or informal hearing on the matter to any person engaged in manufacturing, preparing, compounding, or processing such drug entity who shows reasonable ground for such a hearing.

(3) Any person engaged in the manufacture, preparation, compounding, or processing of any drug entity (or dosage forms or strengths thereof) not included in the Formulary which such person believes to possess the requisite qualities to entitle such drug to be included in the Formulary pursuant to subsection (b), may petition for inclusion of such drug entity and, if such petition is denied by the Formulary Committee, shall, upon request therefor, showing reasonable grounds for a hearing, be afforded a formal or informal hearing on the matter in accordance with rules and procedures established by such Committee.

Limitations on Medicare Payment for Charges of Providers of Services¹

Sec. 1822. (a) Any provider of services as defined in section 1861 (u), whose services are otherwise reimbursable, under any program under this Act in which there is Federal financial participation on the basis of "reasonable cost", shall not be entitled to a professional fee or dispensing charge or reasonable billing allowance as determined pursuant to this part.

(b) A fee, charge, or billing allowance shall not be payable under this section with respect to any drug entity that (as determined in accordance with regulations) is furnished as an incident to a physician's professional service, and is of a kind commonly furnished in physicians' offices and commonly either rendered without charge or included in the physicians' bills.

Reasonable Allowance for Eligible Drugs²

Sec. 1823. (a) For purposes of this part, the term "reasonable allowance" when used in reference to an eligible drug (as defined in subsection (h) of this section) means the following:

(1) When used with respect to a prescription legend drug entity, in a given dosage form and strength, such term means the lesser of—

(A) an amount equal to the customary charge at which the participating pharmacy sells or offers such drug entity, in a given dosage form and strength, to the general public, or

(B) the price determined by the Secretary, in accordance with subsection (b) of this section, plus the professional fee or dispensing charges determined in accordance with subsection (c) of this section.

(2) When used with respect to insulin such term means the charge not in excess of the reasonable customary price at which the participating pharmacy offers or sells the product to the general public, plus a reasonable billing allowance.

¹ Applies with respect to eligible drugs furnished on and after July 1, 1973.

² Applies with respect to eligible drugs furnished on and after July 1, 1973.

(b)(1) *For purposes of establishing the reasonable allowance in accordance with subsection (a) the price shall be (A) in the case of a drug entity (in any given dosage form and strength) available from and sold by only one supplier, the price at which such drug entity is generally sold (to establishments dispensing drugs), and (B) in any case in which a drug entity (in any given dosage form and strength) is available and sold by more than one supplier, only each of the lower prices at which the products of such drug entity are generally sold (and such lower prices shall consist of only those prices of different suppliers sufficient to assure actual and adequate availability of the drug entity, in a given dosage form and strength, at such prices in a region).*

(2) *If a particular drug entity (in a given dosage form and strength) in the Formulary is available from more than one supplier, and the product of such drug entity as available from one supplier possesses demonstrated distinct therapeutic advantages over other products of such drug entity as determined by the Committee on the basis of its scientific and professional appraisal of information available to it, including information and other evidence furnished to it by the supplier of such drug entity, then the reasonable allowance for such supplier's drug product shall be based upon the price at which it is generally sold to establishments dispensing drugs.*

(3) *If the prescriber, in his handwritten order, has specifically designated a particular product of a drug entity (and dosage form and strength) included in the Formulary by its established name together with the name of the supplier of the final dosage form thereof, the reasonable allowance for such drug product shall be based upon the price at which it is generally sold to establishments dispensing drugs.*

(c)(1) *For the purpose of establishing the reasonable allowance (in accordance with subsection (a)) a participating pharmacy, shall, in the form and manner prescribed by the Secretary, file with the Secretary, at such times as he shall specify, a statement of its professional fee or other dispensing charges.*

(2) *A participating pharmacy, which has agreed with the Secretary to serve as a provider of services under this part, shall, except for subsection (a)(1)(A), be reimbursed, in addition to any price provided for in subsection (b), the amount of the fee or charges filed in paragraph (1), except that no fee or charges shall exceed the highest fee or charges filed by 75 per centum of participating pharmacies (with such pharmacies classified on the basis of (A) lesser dollar volume of prescriptions and (B) all others) in a census region which were customarily charged to the general public as of June 1, 1972. Such prevailing professional fees or dispensing charges may be modified by the Secretary in accordance with criteria and types of data comparable to those applicable to recognition of increases in reasonable charges for services under section 1842.*

(3) *A participating pharmacy shall agree to certify that, whenever such pharmacy is required to submit its usual professional fee or dispensing charge for a prescription, such charge does not exceed its customary charge.*

**Part B—Supplementary Medical Insurance Benefits for the Aged
and Disabled**

**Establishment of Supplementary Medical Insurance Program for
the Aged and the Disabled**

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

Scope of Benefits

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

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

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

- (B) medical and other health services [(other than physicians' services unless furnished by a resident or intern of a hospital and the services for which payment may be made pursuant to section 1835 (b) (2))] furnished by a provider of services or by others under arrangements with them made by a provider of services; [and]¹, *excluding—*

- (i) *physician services except where furnished by—*

- (I) *a resident or intern of a hospital, or*

- (II) *a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861 (b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, and*

- (ii) *services for which payment may be made pursuant to section 1835 (b) (2);*

- (C) *outpatient physical therapy services[.];*

- (D) *outpatient speech pathology services;*²

- (E) *outpatient clinical psychologists' services; and*³

- (F) *outpatient rehabilitation service.*⁴

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

¹ Applies to accounting periods beginning after December 31, 1972.

^{2 3 4} Applies to services furnished with respect to admissions occurring after December 31, 1972.

Payment of Benefits

Sec. 1833. (a) **[Subject to]** *Except as provided in section 1876, and subject to*¹ the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), **[and]** (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) *with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, and (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and*

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

(A) *the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or*

(B) *if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2).*

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$50, except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied

¹ Applies to services furnished with respect to admissions occurring after December 31, 1972.

toward such individual's deductible under this section for such preceding year, and (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

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

- (1) \$312.50, or
- (2) 62½ percent of such expenses.

The provisions of this subsection shall apply with respect to outpatient clinical psychologists' services as defined in section 1861(bb).

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

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

(f) (1) In the case of the purchase of durable medical equipment included under section 1861(s) (6), by or on behalf of an individual, payment shall be made in such amounts as the Secretary determines to be equivalent to payments that would have been made under this part had such equipment been rented and over such period of time as the Secretary finds such equipment would be used for such individual's medical treatment, except that [with respect to purchases of inexpensive equipment (as determined by the Secretary)] (A) payment may be made in a lump sum if the Secretary finds that such method of payment is less costly or more practical than periodic payments, and (B) with respect to purchases of used equipment the Secretary is authorized to waive the

20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

(2) In the case of rental of durable medical equipment, the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible.

(g) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.

Limitation on Home Health Services

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

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

Procedure for Payment of Claims of Providers of Services

Sec. 1835. (a) Except as provided in [subsections (b) and (c)] subsections (b), (c), and (e),¹ payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

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

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient admin-

¹ Applies to accounting periods beginning after December 31, 1972.

*istration so requires, such period may be reduced to not less than 1 calendar year; and*¹

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

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; and

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services [on an outpatient basis],² (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]; and

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;³ and

(E) in the case of outpatient clinical psychologists' services, (i) such services are or were required because the individual needed clinical psychology services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;⁴ and

(F) in the case of outpatient rehabilitation services, (i) such services are or were required because the individual needed outpatient rehabilitation services, including physical therapy or speech pathology services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.⁵

¹ Applies in the case of services furnished (or deemed to have been furnished) after 1970.

² Applies to items furnished on or after date of enactment.

³ Applies to services rendered after December 31, 1972.

⁴ Applies to services rendered after December 31, 1972.

⁵ Applies to services rendered after December 31, 1972.

For purpose of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services [as therein defined], *outpatient speech pathology services, outpatient clinical psychologists' services, and outpatient rehabilitation services, as defined in sections 1861(p), 1861(aa), 1861(bb), and 1861(cc), respectively.* To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

(b)(1) Payment may also be made to any hospital for services described in section 1861(s) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1814(d)(1)(C) with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1833(a)(2) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1814(d)(1)(C), to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1833, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Notwithstanding the provisions of this section and sections 1832, 1833, and 1866(a)(1)(A), a hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1861(s) and furnished to him by such hospital as an outpatient, but only if such charges for such services do not exceed \$50, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1833(a)(1). Payments under this title to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position

it would have been had it instead been reimbursed in accordance with section 1833(a)(2).

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

(e) *For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1861(b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (2) for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if¹—*

(1) such hospital has an agreement with the Secretary under section 1866, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care to patients in such hospital or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged provision will be made for return for any moneys incorrectly collected).

Eligible Individuals

Sec. 1836. Every individual who—

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

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

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

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

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

Enrollment Periods

Sec. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be

¹ Applies to accounting periods beginning after December 31, 1972.

prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) (1) No individual may enroll for the first time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the close of the first enrollment period during which he could have enrolled under this part.

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

(b) *No individual may enroll under this part more than twice.*

(c) In the case of individuals who first satisfy [paragraphs (1) and] *paragraph (1) or (2) of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on May 31, 1966. [For purposes of this subsection and subsection (d), an individual who satisfies paragraph (2) of section 1836 solely by reason of subparagraph (B) thereof shall be treated as satisfying such paragraph (2) on the first day on which he is (or on filing application would be) entitled to hospital insurance benefits under part A.] For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.*

(d) In the case of an individual who first satisfies [paragraphs (1) and (2)] *paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).*

(e) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on January 1 and ending on March 31 of each year beginning with 1969.

(f) *Any individual—*

(1) *who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and*

(2) *whose initial enrollment period under subsection (d) begins after March 31, 1973, and*

(3) *who is residing in the United States, exclusive of Puerto Rico,*

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th consecutive month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2) (A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 or section 1819 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (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) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.¹

Coverage Period

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

(1) **July 1, 1966** July 1, 1966 or (in the case of a disabled individual who has not attained age 65) July 1, 1973, or

¹ Effective as of July 1, 1966.

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

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

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

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

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

(3) (A) *in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or*

(B) *in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.*

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

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period [(not in excess of 90 days)]¹ in which overdue premiums may be paid and coverage continued. *The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.*

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does

¹ Applies to nonpayment of premiums which become due and payable on or after the date of enactment or which became payable within the 90-day period immediately preceding such date; and for purposes of this amendment any premium which became due and payable within such 90-day period shall be considered a premium becoming due and payable on the date of enactment.

not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837(b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.

(c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

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

Amounts of Premiums

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

(b) (1) The monthly premium of each individual enrolled under this part for each month after 1967 and before July 1, 1973, shall be the amount determined under paragraph (2).

(2) The Secretary shall, during December 1968 and of each year **[thereafter]** ending on or before December 31, 1971, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 in each succeeding year. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such 12-month period will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for such 12-month period. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin. Whenever the Secretary, pursuant to the preceding sentence, promulgates the dollar amount which shall be applicable for premiums for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of premiums so promulgated.

(c) (1) *The Secretary shall, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 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 payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such 12-month period. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after June 1973 shall, except as provided in subsection (d), be the amount determined under paragraph (3).

(3) The Secretary shall, during December of 1972 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium shall be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that 12-month period, or

(B) the monthly premium rate most recently promulgated by the Secretary, under this paragraph or, in the case of the determination made in December 1971, such rate promulgated under subsection (b) (2) multiplied by the ratio of (i) the amount in column IV of the table which, by reason of the law in effect at the time the promulgation is made, will be in effect as of June 1 next following such determination appears (or is deemed to appear) in section 215(a) on the line which includes the figure "750" in column III of such 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 included the figure "750" in column III as of June 1 of the year in which such determination is made.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 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 such 12-month period with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

[(c)] (d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12

months (*in the same continuous period of eligibility*) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time. *Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.*

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

[(e)] (f) *For purposes of subsection [(c)] (d) (and section 1837 (g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section)*

Payment of Premiums

Sec. 1840. (a) (1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall (except as provided in [subsection (d)] subsections (b) (1) and (c))¹ be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 or 223 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b) (1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937 (*whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202*), his monthly premiums

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

under this part shall (except as provided in subsection **[(d)](c)**)¹ be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

[(c)] In the case of an individual who is entitled both to monthly benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.²

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

[(e)](d) (1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 of title 5, United States Code, may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him

¹ Applies to premiums due and payable after the fourth month following the month of enactment.

² Applies to premiums becoming due and payable after the fourth month following the month of enactment.

under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

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

[(f)] (e) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection [(d)](c)¹ applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

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

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

[(i)] (h) In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1843 is applicable, subsection (a), (b), (c), [(d), and (e)] and (d)² of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1843(d).

Federal Supplementary Medical Insurance Trust Fund

Sec. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of *such gifts and bequests as may be made as provided in section 201 (i) (1), and*³ such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

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

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

² Applies to premiums becoming due and payable after the fourth month following the month of enactment.

³ Applies to gifts and bequests received after date of enactment.

Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

- (1) Hold the Trust Fund;
- (2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;
- (3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and
- (4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

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

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

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

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

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

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

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

(i) *The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1840(b)*

(1). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.¹

Use of Carriers for Administration of Benefits

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

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services *on a reasonable charge basis*,¹ the Secretary shall to the extent possible enter into such contracts:

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

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

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

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

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

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

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

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

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

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

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

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis,

¹ Applies to accounting periods beginning after December 31, 1972.

such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870 (f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is \$100 or more¹ when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

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

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

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

¹ Applies to hearings requested (under the procedures established under section 1842(b)(3)(C) of the Act) after the date of enactment.

No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) 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 the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lower charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary.¹ The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.²

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

(5) *No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over*

¹ Applies to notices sent to individuals after 1968.

² Applies to bills submitted and requests for payment made after March 1968.

*his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.*¹

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

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

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

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

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

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

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

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

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups

¹ Applies with respect to bills submitted and requests for payments made after the date of enactment.

described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

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

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

(2) individuals receiving money payments under all of the plans of such State approved under titles I, X, XIV, XV, and XVI, and part A of title IV. *Effective January 1, 1974, and subject to section 1902(e), the Secretary at the request of any State shall, notwithstanding the repeal of titles I, X, and XIV by section 303(a) of the Social Security Amendments of 1972 and the amendments made to title XVI and part A of title IV by sections 301 and 302 and sections 401 and 403 of such amendments, continue in effect the agreement entered into under this section with such State insofar as it includes individuals who are eligible to receive benefits under title XV or part A of title IV, or supplementary security income benefits under title XVI (as in effect after December 31, 1973), or are otherwise eligible to receive medical assistance under the plan of such State approved under title XIX. The provisions of subsection (h)(2) of this section as in effect before the effective date of the repeals and amendments referred to in the preceding sentence shall continue to apply with respect to individuals included in any such agreement after such date.*

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

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

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

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

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

(A) July 1, 1966;

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

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

(D) such date as may be specified in the agreement; and

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

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

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

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

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, X, XIV, XV, or XVI or part A of title IV, or receiving supplemental security income benefits under title XVI (as in effect after December 31, 1973), or eligible to receive medical assistance under the plan of such State approved under title XIX, if the agreement entered into under this section so provides, the term "carrier" as defined in section 1842 (f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI, and part A of title IV, and individuals eligible to receive medical assistance under the plan of the State approved under title XIX.

(g) (1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d) (2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)),

(B) subsection (d) (3) (B) shall not apply so long as there is in effect a modification entered into by the State under this subsection, and

(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such individual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month).

(h) (1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any *individual* who would (but for this subsection) be excluded from the agreement, subsections (c) and (d) (2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d) (2) (C) shall be applied by substituting "second month following the first month" for "first month."

Appropriations to Cover Government Contributions and Contingency Reserve

Sec. 1844. (a) There are authorized to be appropriated from time to time out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1) (A) a Government contribution equal to the aggregate premiums payable *for a month for enrollees age 65 and over* under this part and deposited in the Trust Fund, [and] *multiplied by the ratio of—*

(i) *twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over, as determined under section 1839(c) (1) for such month, minus the dollar amount of the premium per enrollee for such month as determined under section 1839(c) (3), to*

(ii) *the dollar amount of the premium per enrollee for such month, plus*

(B) a Government contribution equal to the aggregate premiums payable *for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—*

(i) *twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(c) (4) for such month, minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(c) (3), to*

(ii) *the dollar amount of the premium per enrollee for such month.*¹

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during

¹ Effective with respect to enrollee premiums payable for months after June 1973.

the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to \$18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

Eligibility of Individuals, Age 60 Through 64, Who Are Entitled to Benefits Under Section 202 or Who Are Spouses of Individuals Entitled to Hospital Insurance

Sec. 1845. (a) *Any individual who meets the conditions of paragraphs (1) and (2) of section 1819(a) shall be eligible to enroll in the insurance program established by this part. The provisions of subsections (b), (c), (e), (f), and (h) of section 1819 shall apply to individuals authorized to enroll under this section.*

(b) *An individual's coverage period shall also terminate when (A) he no longer meets the conditions specified in paragraphs (1) and (2) of section 1819(a) or (B) his enrollment under section 1819 is terminated. Where termination occurs pursuant to this subsection, the coverage period shall terminate with the close of whichever of the following months is the earliest: (C) the month before the month the individual attains the age of 65 or (D) the month following the month in which such individual no longer meets the conditions of paragraph (2) of section 1819(a) or (E) the month in which his enrollment under section 1819 terminates.*

(c) (1) *The monthly premium of each individual under this section for each month in his coverage period before July 1974 shall be 200 per centum of the premium payable by an individual who has attained age 65 for such month.*

(2) *The Secretary shall, during December of each year beginning in 1973, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be actuarially adequate on a per capita basis to meet the estimated amounts of incurred claims and administrative expenses for individuals enrolled under this section during such period, and such amount shall take into consideration underwriting losses or gains incurred during prior years. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest \$1 or if midway between multiples of \$1, to the next higher multiple of \$1.*

(d) *All premiums collected from individuals enrolled pursuant to this section shall be deposited in the Federal Supplementary Medical Insurance Trust Fund.*

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

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

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

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

Inpatient Hospital Services

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

(1) bed and board;

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

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

excluding, however—

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

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

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

(6) *an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association; or*¹

(7) *a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients.*

Inpatient Psychiatric Hospital Services

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

Inpatient Tuberculosis Hospital Services

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

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f)² and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

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

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse

¹ Applies with respect to accounting periods beginning after December 31, 1972.

² Applies to accounting periods after June 30, 1972.

or registered professional nurse on duty at all times except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

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

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; **[and]**

(8) *has in effect an overall plan and budget that meets the requirements of subsection (z);*¹ and

(9) **[(8)]** meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution. **[except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863).]**

For purposes of subsection (a) (2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), *section 1814(f) (2)*,⁵⁰ and subsections (i) and (n) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j) (1) (A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. *For purposes of sec-*

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

tion 1814(f) (1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f) (2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals.¹

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

Psychiatric Hospital

- (f) The term "psychiatric hospital" means an institution which—
- (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;
 - (2) satisfies the requirements of paragraphs (3) through [(8)] (9)² of subsection (e);
 - (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;
 - (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and
 - (5) is accredited by the Joint Commission on Accreditation of Hospitals.

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

¹ Applies to services furnished with respect to admissions occurring after Dec. 31, 1971.

² Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

Tuberculosis Hospital

- (g) The term "tuberculosis hospital" means an institution which—
- (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;
 - (2) satisfies the requirements of paragraphs (3) through [(8)] (9)¹ of subsection (e);
 - (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;
 - (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and
 - (5) is accredited by the Joint Commission on Accreditation of Hospitals.

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

Extended Care Services

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

- (1) nursing care provided by or under the supervision of a registered professional nurse;
- (2) bed and board in connection with the furnishing of such nursing care;
- (3) physical, occupational, or speech therapy furnished by the [extended care] *skilled nursing* facility or by others under arrangements with them made by the facility;
- (4) medical social services;
- (5) such drugs, biologicals, supplies, applicances, and equipment, furnished for use in the [extended care] *skilled nursing* facility as are ordinarily furnished by such facility for the care and treatment of inpatients;
- (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and
- (7) such other services necessary to the health of the patients as are generally provided by [extended care] *skilled nursing* facilities;

¹ See footnote 2 on page 1024.

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

Post-Hospital Extended Care Services

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

(A) *within 14 days after discharge from such hospital, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital;* an individual shall be deemed not to have been discharged from [an extended care] a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other [extended care] skilled nursing facility.

[Extended Care] Skilled Nursing Facility

(j) The term ["extended care] "skilled nursing facility" means (except for purposes of subsection (a) (2)) an institute (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

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

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

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

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

(5) maintains clinical records on all patients;

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

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

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

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

(10) has in effect an overall plan and budget that meets the requirements of subsection (z);¹

(11) supplies full and complete information to the Secretary or his delegate as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such skilled nursing facility, (B) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (C) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied;²

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);³

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes;⁴ and

[10] (14) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution

¹ Applies to any provider of services for fiscal years (of such provider beginning after the fifth month following the month of enactment.

² Applies on or after July 1, 1973.

³ Applies on or after July 1, 1973.

⁴ Applies on or after July 1, 1973.

which meets the requirements of paragraph (1) of this subsection. The term ["extended care"] "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. *To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—*

(A) *such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,*

(B) *such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and*

(C) *such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.*

Utilization Review

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

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

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

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

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after oppor-

tunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or **[extended care]** *skilled nursing* facility where, because of the small size of the institution, or (in the case of **[an extended care]** *a skilled nursing* facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. *If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.*

Agreements for Transfer Between **[Extended Care] *Skilled Nursing* Facilities and Hospitals**

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

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

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

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

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a

physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

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

(2) physical, occupational, or speech therapy;

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

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

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

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

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

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

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

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

Post-Hospital Home Health Services

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

Home Health Agency

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

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

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

(3) maintains clinical records on all patients;

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

(5) *has in effect an overall plan and budget that meets the requirements of subsection (2); and*¹

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

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in section 1861(r)(1)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician (as so defined);

excluding, however—

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

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or skilled nursing facility.¹

(5) For purposes of subsections (a), (b), and (bb) the term "free standing rehabilitation facility" means a facility where only one form of rehabilitation services shall be required to be provided if such service is speech pathology or clinical psychology, respectively.²

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls [(but not including services described in the last sentence of subsection (b))] (but not including services described in subsection (b) (6)).³

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a

¹ Applies to services furnished on or after the date of enactment.

² Applies to services rendered after December 31, 1972.

³ Applies to accounting periods beginning after December 31, 1972.

physician within the meaning of section 1101(a)(7)), (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act¹ [or] (3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses,² or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.³ For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.⁴

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services;

- (1) physicians' services;
- (2) (A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;
- (B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;
- (C) diagnostic services which are—
 - (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

¹ Applies to admissions occurring after the second month following the month of enactment.

² Applies only with respect to services performed on or after the date of enactment.

³ Applies to services furnished after June 30, 1973.

⁴ Applies to services furnished with respect to admissions occurring after December 31, 1972.

- (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study [and];
- (D) outpatient physical therapy services;
- (E) *outpatient speech pathology services*; ¹
- (F) *outpatient clinical psychologists' services*; ² and
- (G) *outpatient rehabilitation services*; ³
- (3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary); diagnostic laboratory tests, and other diagnostic tests;
- (4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- (5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- (6) durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased;
- (7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;
- (8) prosthetic devices (other than dental) which replace all or part of an internal body organ (*including colostomy bags and supplies directly related to colostomy care*) including replacement of such devices; and
- (9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

- (10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality, responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and
- (11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

- (12) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

¹ Applies to services rendered after December 31, 1972.

² Applies to services rendered after December 31, 1972.

³ Applies to services rendered after December 31, 1972.

(13) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t) The term "drugs" and the term "biologicals", except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospitals, *or as are approved by the Formulary Committee. The term "eligible drug" means a drug or biological which (A) can be self-administered, (B) requires a physician's prescription (except for insulin), (C) is prescribed when the individual requiring such drug is not an inpatient in a hospital or extended care facility, during a period of covered care, (D) is included by strength and dosage forms among the drugs and biologicals approved by the Formulary Committee, (E) is dispensed (except as provided by section 1814(j)), by a pharmacist from a participating pharmacy, and (F) is dispensed in quantities consistent with proper medical practice and reasonable professional discretion.*¹

Provider of Services

(u) The term "provider of services" means a hospital, [extended care] *skilled nursing facility, [or] home health agency, or pharmacy,*² *or, for purposes of section 1814(g) and section 1835(e), a fund.*³

Reasonable Cost

(v)(1)(A) [The reasonable cost] *Except as provided in paragraph (7), the medicare allowance*⁴ *of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be*⁵ *determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in*

¹ Applies to eligible drugs furnished on and after July 1, 1973.

² Applies to eligible drugs furnished on and after July 1, 1973.

³ Applies to accounting periods beginning after December 31, 1972.

⁴ Applies to eligible drugs furnished on and after July 1, 1973.

⁵ Effective with respect to accounting periods beginning after December 31, 1972.

determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services [.] *may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title,*¹ and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall [(A) take] *(i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title)*² in order that, under the methods of determining costs, the [costs with respect] *necessary costs of efficiently delivering covered services*³ to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and [(B) provide] *(ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.*

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) *Where a hospital has an arrangement with a medical school*

¹ Effective with respect to accounting periods beginning after December 31, 1972.

² Effective with respect to accounting periods beginning after December 31, 1972.

³ Effective with respect to accounting periods beginning after December 31, 1972.

under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if
(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.¹

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B) (i) and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).²

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing provisions of this subparagraph shall not apply to any skilled nursing facility in such State if—

(i) such facility is a distinct part of or directly operated by a hospital, or

(ii) such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reason-

¹ Applies to accounting periods beginning after December 31, 1972.

² Applies to accounting periods beginning after December 31, 1972.

able cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of the costs determined by the application of this subparagraph (without regard to such clause (ii)).

Certification and Approval of Skilled Nursing Facilities

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

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

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

(4) If a provider of services furnishes items or services to an individual which are substantially in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866 (a) (2) (B) (ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.¹

(5) (A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organiza-

¹ Effective with respect to accounting periods beginning after December 31, 1972.

tion specified in the first sentence of section 1861(p), the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for travel time and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.¹

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.²

(6) [4] For purposes of this subsection, the term, "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(8) With respect to any eligible drug, the medicare allowance shall be an amount determined in accordance with section 1823 of this Act.

Arrangements for Certain Services

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

State and United States

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

Post-Hospital Extended Care in Christian Science [extended care] Skilled Nursing Facilities

(y) (1) The term "[extended care] skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified,

¹ Effective with respect to accounting periods beginning on or after December 31, 1972.

² Effective with respect to accounting periods beginning on or after December 31, 1972.

by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a) (2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

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

(A) furnished an individual during such spell of illness in [an extended care] a skilled nursing facility to which paragraph (1) applies after—

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

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

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

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

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

*Institutional Planning*¹

(z) *An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall be considered sufficient if it—*

(1) *provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any*

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

Outpatient Speech Pathology Services

(aa) The term "outpatient speech pathology services" means speech pathology services furnished by a provider of services, a clinic, rehabilitation agency (including a single service rehabilitation facility), or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in subsection (p) relating to physical therapy services, except that the terms "speech pathology" and "speech pathologists" shall be substituted for the terms "physical therapy" and "physical therapists" as used throughout subsection (p). For purposes of this section the term "single service rehabilitation facility" means a facility in which only speech pathology shall be required to be provided.¹

Outpatient Clinical Psychologists' Services

(bb) The term "outpatient clinical psychologists' services" means clinical psychologists' services furnished by a provider of services, a clinic, rehabilitation agency (including a single service rehabilitation facility), or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in such subsection (p) relating to physical therapy services, except that the terms "clinical psychology" and "clinical psychologists" shall be substituted for the terms "physical therapy" and "physical therapists" as used throughout subsection (p). For purposes of this section the term "single service rehabilitation facility" means a facility in which only clinical psychologists' services shall be required to be provided.²

¹ Applies to services rendered after December 31, 1972.

² Applies with respect to services rendered after December 31, 1972.

Outpatient Rehabilitation Services

(cc) The term "outpatient rehabilitation services" means physical therapy, speech pathology, occupational therapy, and medical social services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in subsection (p) relating to physical therapy services except that clause (ii) of paragraph 4(A) is amended by inserting after "physical therapist" the phrase "or speech pathologist, as appropriate," and the term "physical therapy" as used throughout subsection (p) shall be deemed for purposes of this subsection to mean "rehabilitation."¹

Participating Pharmacy

(dd) The term "participating pharmacy" means a pharmacy, or other establishment (including the outpatient department of a hospital) providing pharmaceutical services, (1) which is licensed as such under the laws of the State (where such State requires such licensure or which is otherwise lawfully providing pharmaceutical services) in which such drug is provided or otherwise dispensed in accordance with this title, (2) which has agreed with the Secretary to act as a provider of services in accordance with the requirements of this section, and which complies with such other requirements as may be established by the Secretary in regulations to assure the proper, economical, and efficient administration of this title, (3) which has agreed to submit, at such frequency and in such form as may be prescribed in regulations, bills for amounts payable under this title for eligible drugs furnished under part A of this title, and (4) which has agreed not to charge beneficiaries under this title any amounts in excess of those allowable under this title with respect to eligible drugs except as is provided under section 1813(a)(4), and except for so much of the charge for a prescription (in the case of a drug product prescribed by a physician, of a drug entity in a strength and dosage form included in the Formulary where the price at which such product is sold by the supplier thereof exceeds the reasonable allowance) as is in excess of the reasonable allowance established for such drug entity in accordance with section 1823.²

Exclusions From Coverage

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

- (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;
- (2) for which the individual furnished such items or services

¹ Applies with respect to services rendered after December 31, 1972.

² Applies to eligible drugs furnished on and after July 1, 1973.

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

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

(4) which are not provided within the United States (except for [emergency] inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, *subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished*);¹

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

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations;

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

(9) where such expenses are for custodial care;

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

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

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, *except that payment may be made under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization*;² or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can

¹ Applies to services furnished with respect to admissions occurring after Dec. 31, 1972.

² Applies to admissions occurring after the second month following the month of enactment.

reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

(c) *No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual on or after January 1, 1975, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that such plan or the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that—*

(1) *there is available to each Federal employee or annuitant enrolled in such plan, upon becoming entitled to benefits under part A or B, or both parts A and B of this title, in addition to the health benefits plans available before he becomes so entitled, one or more health benefits plans which offer protection supplementing the protection he has under this title, and*

(2) *the Government or such plan will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of his coverage under this title, or (C) a combination of such contribution and such payment.*

(d) (1) *No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—*

(A) *has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;*

(B) *has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds, with the concurrence of the appropriate program review team appointed pursuant to paragraph (4), to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or*

(C) *has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appro-*

appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(4) For the purposes of paragraph (1) (B) and (C) of this subsection, and clause (F) of section 1866(b) (2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and consumer representatives) in each State which shall, among other things—

(A) undertake to review such statistical data on program utilization as may be submitted by the Secretary,

(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto,

(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1) (B) and (C) of this subsection or clause (F) of section 1866(b) (2), and

(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases.

Consultation With State Agencies and Other Organizations To Develop Conditions of Participation for Providers of Services

Sec. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections

[(e)(8), (f)(4), (g)(4), (j)(10), and (o)(5)] (e)(9), (f)(4), (g)(4), (j)(11), and (o)(6)¹ of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or [extended care] skilled nursing facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency (including a single service rehabilitation facility as defined in section 1861 (aa) or (bb)) or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p) (4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, [extended care] skilled nursing facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. *Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the*

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

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

(c) *The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on the Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).*

Effect of Accreditation

[Sec. 1865. Except as provided in the second sentence of section 1863, an institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861(e) (6).]

Sec. 1865. (a) *Except as provided in subsection (b) and the second sentence of section 1863, if—*

(1) *an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and*

(2) *such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary (on a confidential basis) upon his request (or to such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission,*

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) *paragraph (6) thereof, and*

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with section 1861 (e) (6) or the standard described in such paragraph (4) as the case may be. In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

(b) Notwithstanding any other provision of this title, if the Secretary finds following a survey made pursuant to section 1864(c) that an institution has significant deficiencies (as defined in regulations pertaining to health and safety), such institution shall, after the date of notice of such finding to the hospital and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1861(e).

Agreements With Providers of Services

Sec. 1866. (a) (1) Any provider of services (*except a fund designated for purposes of section 1814(g) and section 1835(e)*)¹ shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

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

(B) *not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year*

¹ Applies to accounting periods beginning after December 31, 1972.

*period to not less than one year if he finds such reduction is consistent with the objectives of this title, and*¹

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

*An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12 month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.*²

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

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

⁴(ii) *Where a provider of services customarily furnishes an individual items or services which are substantially more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this title and which have not been requested by such individual, such provider may (except with respect to emergency services) also charge such individual or other person for such more expensive items or services to the extent that the costs of (or if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed*

¹ Applies in the case of notices sent to individuals after 1968.

² Effective with respect to agreements filed with the Secretary under section 1866 by skilled nursing facilities (as defined in section 1861(j)) before, on, or after date of enactment, but accepted by him on or after such date.

³ Applies with respect to eligible drugs furnished on and after July 1, 1973.

⁴ Effective with respect to accounting periods beginning after December 31, 1972.

exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

(I) the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs substantially in excess of the costs determined to be necessary in the efficient delivery of needed health services under this title by particular providers of services in the area in which such items or services are furnished, and

(II) the provider of services has identified such charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs substantially in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined) and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

(D) Where a provider of services customarily furnishes items or services which are substantially in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

For purposes of [clause (iii) of the preceding sentence] subparagraph (C),¹ whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(b) An agreement with the Secretary under this section may be [terminated—] terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1))—

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

¹ Effective with respect to accounting period beginning after December 31, 1972.

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1862 (d) (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

Any termination shall be applicable—

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

(3) in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

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

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

(c) (1) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not

file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

(2) *In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910, and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.*¹

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861 (k) of long-stay cases in a hospital or [extended care] *skilled nursing* facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of [an extended care] *a skilled nursing* facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency *including a single service rehabilitation facility*,² or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861 (p) (4) (A), or if, in the case of a public health agency, such agency meets the requirements of section 1861 (p) (4) (B), or if, *in the case of a single service rehabilitation facility, such facility meets the requirements of section 1861 (aa), or (bb), whichever is appropriate*,³ but only with respect to the furnishing of outpatient physical therapy services, [(as therein defined)] *outpatient speech pathology services, outpatient clinical psychologists' services, and outpatient rehabilitation services, as defined in sections 1861 (p), 1861 (aa), 1861 (bb) and 1861 (cc).*⁴

Health Insurance Benefits Advisory Council

Sec. 1867. [(a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise

¹ Effective with respect to agreements filed with the Secretary under section 1866 by skilled nursing facilities (as defined in section 1861 (j)) before, on, or after the date of enactment, but accepted by him on or after such date.

² Applies to services rendered after December 31, 1972.

³ Applies to services rendered after December 31, 1972.

⁴ Applies with respect to services rendered after December 31, 1972.

in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Advisory Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 5 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.】

(a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

[(b) It shall be the function of the Advisory Council (1) to advise the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, and (2) to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Advisory Council shall make an annual report to the Secretary on the performance of its functions, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.]

(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.

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

Sec. 1868. [Repealed.]

Determinations; Appeals

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

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

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

Overpayments on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals

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

(b) Where—

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) *that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or*¹

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

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

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

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

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made. *For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.*²

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault [and where] *or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b) (4), if*³ such adjustment (or recovery) would defeat the purposes of title II or title XVIII⁴ or would be against equity and good conscience. *Adjustment or recovery of an incorrect payment*

¹ Applies to notices of payment sent to individuals after date of enactment.

² Applies to notices sent to individuals after 1968.

³ Applies to waiver actions considered after the date of enactment.

⁴ Applies to notices sent to individuals after 1968.

(or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862 and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.¹

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

(e) If an individual, who received services for which payment may be made to such individual under this title, dies, and payment for such services was made (other than under this title), and the individual died before any payments due him under this title with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such require-

¹ Applies to notices sent to individuals after 1968.

ments dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a) (1) dies, and—

(1) no assignment of the right to payments was made by such individual before his death, and

(2) payment for such services has not been made, payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.

(g) *If an individual, who is enrolled under section 1818(c), 1819(b), 1837, or 1845 of the Social Security Act dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sen-*

tence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

Regulations

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

Application of Certain Provisions of Title II

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

Designation of Organization or Publication by Name

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

Administration

Sec. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1937, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

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

(c) *In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.*

Studies and Recommendations

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

(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B (including a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972,¹ the [experimentation] experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967, and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972), and shall transmit to the Congress annually a report concerning the operation of such programs.

*Payments to Health Maintenance Organizations*²

Sec. 1876. (a) (1) *In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—*

(A) *for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and*

(B) *for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under part B.*

(2) *An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3)(A)(iv). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capita costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (e). Each such organization shall submit interim estimated cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretary shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).*

¹ Effective with respect to services provided on or after July 1, 1973.

² Effective with respect to services provided on or after July 1, 1973.

(3) (A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i) (2) (A), payments made to such organization shall be subject to the following adjustments at the end of each contract year:

(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as "savings") shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the "Medicare Trust Funds") as follows:

(I) savings up to 10 percent of the adjusted average per capita costs shall be apportioned equally between such organization and the Medicare Trust Funds;

(II) savings between 10 and 20 percent shall be apportioned one-quarter to such organization and three-quarters to such Trust Funds;

(III) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resulting difference (hereinafter referred to as "losses") shall be apportioned between such organization and the Medicare Trust Funds as follows:

(I) losses up to 10 percent over the adjusted average per capita cost shall be borne equally by such organization and such Trust Funds;

(II) losses between 10 and 20 percent over the adjusted average per capita cost shall be borne three-quarters by such Trust Funds and one-quarter by such organization;

(III) losses in excess of 20 percent over the adjusted average per capita cost shall be borne entirely by such Trust Funds;

(iii) losses absorbed by such organization or by the Medicare Trust Funds in any year shall be carried forward and shall be offset from savings realized in later years, with the apportionment of savings being proportional to the losses absorbed and not yet offset;

(iv) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

(I) within 90 days after close of a contract year, interim determination of the amount of estimated savings or losses and apportionment thereof shall be made, actuarially, on the basis of interim reports of costs incurred by an organization, and adjusted average per capita costs incurred (as defined

herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the Trust Funds shall be paid by such organization or the Secretary as appropriate; and

(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph;

(III) where such final settlement is reached more than 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

(v) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in the geographic area served by a health maintenance organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i) (2) (B), payments made to such organization shall be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordance with

accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v) of the Social Security Act; and

(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(4) The payments to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a) (1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(1), and

(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(4).

The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(b) The term "health maintenance organization" means a public or private organization which—

(1) provides, either directly or through arrangements with others, health services to individuals enrolled with such organization on the basis of a predetermined periodic rate without regard to the frequency or extent of services furnished to any particular enrollee;

(2) provides, either directly or through arrangements with others, to the extent applicable in subsection (c) (through institu-

tions, entities, and persons meeting the applicable requirements of section 1861), the services and benefits covered under parts A and B of this title which are generally available to individuals residing in the geographic area served by the health maintenance organization;

(3) provides physicians' services primarily (A) directly through physicians who are either employees or partners of such organization, or (B) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis;

(4) provides, either directly or under arrangements with others, the services of a sufficient number of primary care and specialty care physicians to meet the health needs of its members; for purposes of this section the term "specialty care physicians" means a physician who is either board certified or eligible for board certification, except that the Secretary may by regulation prescribe conditions under which physicians who have a record of demonstrated proficiency but who are not eligible for board certification may, on the basis of training and experience, be recognized as specialty care physicians;

(5) has effective arrangements to assure that its members have access to qualified practitioners in those specialties which are generally available in the geographic area served by the health maintenance organization;

(6) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;

(7) except as provided in subsection (h), has at least half of its enrolled members consisting of individuals under age 65;

(8) assures that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and

(9) has an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment unless to do so would result in failure to meet the requirements of paragraph (7) or would result in enrollment of enrollees substantially nonrepresentative as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.

(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i) (2) (A) shall consist of—

(1) in the case of an individual who is entitled to hospital

insurance benefits under part A and enrolled for medical insurance benefits under part B—

(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the health maintenance organization with which he is enrolled; and

(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

(d) Subject to the provisions of subsection (e), every individual described in subsection (c) (1) and (2) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is \$100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is \$1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(g) (1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c), its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional

for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion applicable to the services described in subsection (c) may not exceed (i) the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section less (ii) the actuarial value of other charges made in lieu of such deductible and coinsurance.

(h) The provisions of paragraph (7) of subsection (b) shall not apply with respect to any health maintenance organization for such period not to exceed three years from the date such organization enters into an agreement with the Secretary pursuant to subsection (i), as the Secretary may permit, but only so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plans for each year that it is making continuous efforts and progress toward achieving compliance with the provisions of such paragraph (7) within such three-year period.

(i) (1) Subject to the limitations contained in subparagraphs (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of individuals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

(2) (A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 persons in each of the two years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immediately preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings and losses, as determined pursuant to subsection (a) (3) (A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health maintenance organization which has entered into a risk sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear its proportionate share of risk of potential losses as determined under clause (ii) of subsection (a) (3) (A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects,

or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (a) (3) (B).

(3) Such contract may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section 1861(v)) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

(6) Each contract under this section—

(A) Shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

(B) shall provide that no reinsurance costs (other than those with respect to out-of-area services), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iv) of subsection (a) (3) (A), shall be

allowed for purposes of determining payments authorized under this section; and

(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purposes of this title.

Penalties ¹

Sec. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertifi-

¹ Shall not apply to any acts, statements, or representations made or committed prior to the enactment.

ation) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than 6 months, or both.

(d) For purposes of this section the word "whoever" includes corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals.

Provider Reimbursement Review Board¹

Sec. 1878. (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h), if—

(1) such provider—

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1) (A) or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the \$10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, \$10,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made

¹ Applies to cost reports of providers of services, as defined in title XVIII of the Act, for accounting periods ending on or after June 30, 1973.

at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title and regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 205 with respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

(f) A decision of the Board shall 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 (adversely to such provider) the Board's decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within 60 days of the date he is notified of the Secretary's reversal or modification. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

(g) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

Limitation on Liability of Beneficiary Where Medicare Claims Are Disallowed¹

Sec. 1879. (a) Where—

(1) *a determination is made that, by reason of section 1862(a) (1) or (9), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b) (3) (B) (ii), and*

(2) *both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B, then, to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a) (1) and section 1862(a) (9) did not apply. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services.*

(b) *In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs), subject to the deductible and coinsurance provisions of this title, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enact-*

¹ Effective with respect to claims under title XVIII. filed—

(1) after the month of enactment, or

(2) in or before the month of enactment if such claim is with respect to items or services furnished after June 30, 1971, and if—

(A) notice of the final decision of the Secretary has not been given to the applicant in or before such month, or

(B) notice of final decision of the Secretary has been so given in or before such month, but a civil action with respect to such final decision is commenced under section 1869(b) (whether before, in, or after such month) and the decision in such civil action has not become final in or after such month.

ment of this section), be deemed to have knowledge that payment cannot be made for such items or services.

(c) No payments shall be made under this title in any case in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of services or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862 (a) (1) or (a) (9).

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under section 1869 (b) (when the determination is under part A) or section 1842 (b) (3) (C) (when the determination is under part B) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Appropriation

Sec. 1901. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

State Plans for Medical Assistance

- Sec. 1902.** (a) A State plan for medical assistance must—
- (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;
 - (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;
 - (3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical

assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged);

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) [provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;] *provide—*

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864 (a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing

and maintaining standards, other than those relating to health, for such institutions;

(10) provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I, X, XIV, XV, and XVI, and part A of title IV or receiving a supplemental security income payment under title XVI (as in effect after December 31, 1973) and who would, except for such payment, be eligible for such medical assistance under the State plan or who would have been eligible for such medical assistance under the medical assistance standard as in effect on January 1, 1972 (except that in determining income for this purpose, expenses incurred for medical care must be deducted); and

(A) provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such State plan, and

(ii) shall not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals [not receiving aid or assistance under any such plan] pursuant to subparagraph (B) (ii); and

(B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary or who are individuals receiving supplemental security income benefits under title XVI (as in effect after December 31, 1973) (which for the purposes of this subparagraph shall be considered to be a State plan) but who are not eligible under subparagraph (A), provide—

(i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan or who are receiving a supplemental security income payment under title XVI (as in effect after December 31, 1971) and who would, except for such payment, be eligible for medical assistance under the State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care and services, and

(ii) that the medical or remedial care and services made available to all individuals [not receiving aid or assistance under any such State plan] under clause (i) of this subparagraph shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4) or (14) of section 1905(a) to individuals meeting the age requirement prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, and (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of the deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope to any other individuals;

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan; and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under title V and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1903;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for inclusion of some institutional and some noninstitutional care and services, and

(B) in the case of individuals receiving aid or assistance under the State's plan approved under title I, X, XIV, XV, or XVI, or part A of title IV, *who are described in paragraph (10) with respect to whom medical assistance must be made available*, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905 (a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905 (a) or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (14) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing [home] facility services, physicians' services to an individual in a hospital or skilled nursing [home] facility during any period he is receiving hospital services from such hospital or skilled nursing [home] facility services from such home, and

(D) for payment of the reasonable cost (as determined in accordance with standards, *consistent with section 1122*, approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan; and

(E) *effective July 1, 1974, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;*

[(14) provide that (A) in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, XVI, and part A of title IV, no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services or any other medical assistance furnished to an individual thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources:]¹

(14) *effective January 1, 1973, provide that—*

(A) *in the case of individuals receiving aid or assistance under a State plan approved under title I, X, XIV, XV, or XVI, or part A of title IV, or who meet the income and resources requirements of the one of such State plans which is appropriate, or, after December 31, 1973, are required to be covered under Section 1902(a)(10)(A) or who meet the income and resources requirement of the plans specified in that Section, no enrollment fee, premium, or similar charge, and no deductible, cost sharing, or similar charge will be imposed under the plan, and*

(B) *with respect to individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such State plans which is appropriate or who, after December 31, 1973, are included under the State plan for medical assistance approved under title XIX pursuant to Section 1902(a)(10)(B)—*

¹ Effective July 1, 1973 (or earlier if the State plan so provides).

(i) there shall be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal and limited to those elective services (such as initial office visits to physicians and dentists) which are usually—but not necessarily—initiated by such individuals;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan [who are not receiving aid or assistance under the State's plan approved under title I, X, XIV, or XVI, or part A of title IV,] other than those described in paragraph (10) with respect to whom medical assistance must be made available, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient, and (in the case of any applicant or recipient who would, if he met the requirements as to need, be eligible for aid or assistance in the form of money payments under a State plan approved under title I, X, XIV, or XVI, or part A of title IV) as would not be disregarded (or set aside for future needs) in determining his eligibility for and amount of such aid or assistance under such plan, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or is blind or [permanently and totally] disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the

extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or [permanently and totally] disabled of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institutions, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services [referred to in 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii)] *which the State agency administering the plan approved under title XV or XVI determines to make available or, after December 31, 1973, which the agency administering the program of supplemental security income benefits under title XVI (as in effect after December 31, 1973) determines to make available* which are appropriate for such recipients and

for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality; and

(23) provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; *and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;*

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing homes, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed to determine payments

due under this Act on account of care and services furnished to individuals;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17) (B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical **evaluation**) of each patient's need for skilled nursing **home care** facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing **home** facility; (B) for periodic inspections to be made in all skilled nursing homes and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of (i) the care being provided in such nursing homes (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing homes (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such homes (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing homes (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete report of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request;

(28) provide that any skilled nursing home receiving payments under such plan must—

(A) supply to the licensing agency of the State full and complete information as to the identity (i) of each person

having (directly or indirectly) an ownership interest of 10 per centum or more in such nursing home, (ii) in case a nursing home is organized as a corporation, of each officer and director of the corporation, and (iii) in case a nursing home is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied;

[(B) have and maintain an organized nursing service for its patients, which is under the direction of a professional registered nurse who is employed full-time by such nursing home, and which is composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week;

[(C) make satisfactory arrangements for professional planning and supervision of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed;

[(D) have satisfactory policies and procedures relating to the maintenance of medical records on each patient of the nursing home, dispensing and administering of drugs and biologicals, and assuring that each patient is under the care of a physician and that adequate provision is made for medical attention to any patient during emergencies;

[(E) have arrangements with one or more general hospitals under which such hospital or hospitals will provide needed diagnostic and other services to patients of such nursing home, and under which such hospital or hospitals agree to timely acceptance, as patients thereof, of acutely ill patients of such nursing home who are in need of hospital care; except that the State agency may waive this requirement wholly or in part with respect to any nursing home meeting all the other requirements and which, by reason of remote location or other good and sufficient reason, is unable to effect such an arrangement with a hospital; and

[(F) (i) meet (after December 31, 1969) such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that the State agency may waive in accordance with regulations of the Secretary, for such periods as it deems appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the patients of such skilled nursing home; and except that the requirements set forth in the preceding provisions of this subclause (i) shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes; and (ii) meet conditions relating to environment and sanitation applicable

to extended care facilities under title XVIII; except that the State agency may waive in accordance with regulations of the Secretary for such periods as it deems appropriate, any requirement imposed by the preceding provisions of this subclause (ii) if such agency finds that such requirement, if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the patients of such nursing home;]

(28) *provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title, if the State plan includes care in such institutions;*

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (*including but not limited to utilization review plans as provided for in section 1903(i)(4)*) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care; [and]

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility [which provides more than a minimum level of health care services] as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State 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 in such intermediate care facilities to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency

administering or supervising the administration of the State plan;

(32) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the last sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864 (a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that the State agency will not enter into any contract related to the administration of such plan unless such contract provides—

(A) that the contractor agrees that such State agency, the Secretary, the Inspector General for Health Administration, and the Comptroller General of the United States shall have access to and the right to examine—

(i) the consolidated cost and financial data of such

contractor (and of any organization which is related through common ownership and control to such contractor) whenever the aggregate contract costs exceed \$25,000, and

(ii) any directly pertinent financial books and related documents, papers, and records of such contractor (and of any such related organization) regardless of the amount of such contract; and

(B) that the contractor agrees to include in all his subcontracts a provision to the effect that the subcontractor agrees that the consolidated cost and financial data of such subcontractor (and of any organization related to such subcontractor) as well as any directly pertinent financial books and related documents, papers, and records of such subcontractor (and of any such related organization) shall be subject to inspection and examination in the manner prescribed in subparagraph (A);

(36) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and

(37) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

[Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administra-

tion of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).】

For purposes of paragraphs (9) (A), (29), (32), and (33), and of section 1903(i) (4), the term "skilled nursing facility" and "nursing facility" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 【21】 22 and is or would, except for the provisions of section 【406(a) (2)】 411(a) (1) (A) (ii) of this title, be a dependent child under part A of subchapter IV of this chapter; or
- (3) any residence requirement which excludes any individual who resides in the State; or
- (4) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs) provided for eligible individuals under a plan of such State approved under title I, X, XIV, or XVI, or part A of title IV.

【(d) Whenever any State desires a modification of the State plan for medical assistance so as to reduce the scope or extent of the care and services provided as medical assistance under such plan, or to terminate any of such care and services, the Secretary shall, upon application of the State, approve any such modification if the Governor of such State certifies to the Secretary that—

- (1) the average quarterly amount of non-Federal funds expended in providing medical assistance under the plan for any consecutive four-quarter period after the quarter in which such modification takes effect will not be less than the average quarterly amount of such funds expended in providing such assistance for the four-quarter period which immediately precedes the quarter in which such modification is to become effective,
- (2) the State is fully complying with the provisions of its State plan (relating to control of utilization and costs of services) which are included therein pursuant to the requirements of subsection (a) (30), and
- (3) the modification is not made for the purpose of increasing the standard or other formula for determining payments for those types of care or services which, after such modification, are provided under the State plan,

and if the Secretary finds that the State is complying with the provisions of its State plan referred to in clause (2); except that nothing in this subsection shall be construed to authorize any modification in the State plan of any State which would terminate the care or services required to be included pursuant to subsection (a)(13) of this section. Any increase in the formula or other standard for determining payments for those types of care or services which, after such modification, are provided under the State plan shall be made only after approval thereof by the Secretary.】

(e) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that—

(1) each family which was eligible for assistance pursuant to part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for such assistance for 12 calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of the income and resources limitations contained in such plan;

(2) upon the expiration of such 12 calendar months, any such family may at its option continue to be eligible for medical assistance upon payment of a monthly premium, to the State agency responsible for administration of the plan, in an amount equal to 20 percent of the portion of such family's combined income from whatever source which is in excess of \$200 per month, except that any amounts received as work bonus payments under section 10001 of the Internal Revenue Code of 1954 shall not be counted for purposes of determining such family's income; and

(3) any family which was not eligible for medical assistance under such State plan but where a member of such family began to participate in the employment program established by title XX of this Act may, at its option, become eligible for medical assistance under such State plan upon payment of a monthly premium in the same manner and amount, and subject to the same conditions, as described in paragraph (2) of this subsection.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State shall be required to provide medical assistance to any aged, blind, or disabled individual (as defined in title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting such individual's payment under title XVI and incurred expenses for medical care as defined in section 213 of the Internal Revenue Code of 1954) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972.

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section **[and section 1117]**) shall pay to each State which has a plan approved under this title, for each quarter. **[beginning with the quarter commencing January 1, 1966.]**

- (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), *subject to subsections (g) and (h) of this section*) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are recipients of **[money payments]** *aid or assistance* under a state plan approved under title I, X, XIV, XV, or XVI, or part A of title IV, or supplemental security income benefits under title XVI of such Act (as in effect after December 31, 1973) assistance to needy families with children as defined in section 405(b) or assistance for aged, blind, and disabled under title XX, or payments for foster care in accordance with section 406, and, except in the case of individuals sixty-five years of age or older who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus
- (2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to (A) compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency **[; plus]** and (B) reasonable payment for professional review activities, performed by skilled professional medical personnel and staff directly supporting such personnel pursuant to section 1902(a)(26) and (31), regardless of whether such activities are performed by State agency personnel or by others under an arrangement with such agency; plus
- [**(3) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.**]**
- (3) an amount equal to 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000); plus
- (4) an amount equal to 100 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine

whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus

(5) an amount equal to 100 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the plan) which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

【(4)】 *(6) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.*

【(b) (1) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.】

【(2)】 *(b) (1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a) (1) for any State for any quarter beginning after December 31, 1967, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII.*

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

【(c) (1) If the Secretary finds, on the basis of satisfactory information furnished by a State, that the Federal medical assistance percentage for such State applicable to any quarter in the period beginning January 1, 1966, and ending with the close of June 30, 1969, is less than 105 per centum of the Federal share of medical expenditures by the State during the fiscal year ending June 30, 1965 (as determined under paragraph (2)), then 105 per centum of such Federal share shall be the Federal medical assistance percentage (instead of the

percentage determined under section 1905(b)) for such State for such quarter and each quarter thereafter occurring in such period and prior to the first quarter with respect to which such a finding is not applicable.

[(2) For purposes of paragraph (1), the Federal share of medical expenditures by a State during the fiscal year ending June 30, 1965, means the percentage which the excess of—

[(A) the total of the amounts determined under sections 3, 403, 1003, 1403, and 1603 with respect to expenditures by such State during such year as aid or assistance under its State plans approved under titles I, IV, X, XIV, and XVI, over

[(B) the total of the amounts which would have been determined under such sections with respect to such expenditures during such year if expenditures as aid or assistance in the form of medical or any other type of remedial care had not been counted, is of the total expenditures as aid or assistance in the form of medical or any other type of remedial care under such plans during such year.]

[(d)](c)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[(e) The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satis-

factory 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 with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.】

【(f)】(d) (1) (A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B) (i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 $\frac{1}{3}$ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1) (B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 408) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual who, at the time of the provision of the medical assistance giving rise to such expenditure—

(A) is a recipient of aid or assistance under a plan of such State which is approved under title I, X, XIV, XV, or XVI, or part A of title IV or supplemental security income benefits under

title XVI of such act (as in effect after December 31, 1973), or

(B) is not a recipient of aid or assistance under such a plan but (i) is eligible to receive such aid or assistance, or (ii) would be eligible to receive such aid or assistance if he were not in a medical institution.

(e)(1) *With respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33 $\frac{1}{3}$ per centum thereof unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—*

(A) *in each case for which payment is made under the State plan, a physician certifies at the time of admission, or if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and*

(B) *in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;*

(C) *such State has in effect a continuous program of review of utilization pursuant to section 1902(a)(30) whereby the necessity for admission and the continued stay of each patient in such institution is periodically reviewed and evaluated (with such frequency as may be prescribed in regulations of the Secretary) 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 such institution; and*

(D) *such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing homes, and intermediate care facilities pursuant to section 1902(a)(26) and (31) whereby the professional management of each case is re-*

viewed and evaluated at least annually by independent professional review teams.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(f) (1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by an amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing facility services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved under this title.

(g) (1) With respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing home or intermediate care facilities on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the

same fiscal year shall be decreased by $33\frac{1}{3}$ per centum thereof unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing home services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuance program of review of utilization pursuant to section 1902(a)(30) whereby the necessity for admission and the continued stay of each patient in such institution is periodically reviewed and evaluated (with such frequency as may be prescribed in regulations of the Secretary) 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 such institution; and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing homes, and intermediate care facilities pursuant to section 1902(a)(26) and (31) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(h)(1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing home services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expendi-

tures under the State plan by an amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the statewide average cost of skilled nursing home services and the statewide average cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing home services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved under this title.

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the third, fourth, and fifth sentences of section 1842(b)(3); or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972 by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing home has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and pro-

cedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

(j) (1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

(2) The Secretary may issue a suspension of payment order with respect to any institution if—

(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

(B) (i) the Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5)) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such

institution shall be made to such State for the month in which such order ceases to be effective.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1876 for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.¹

Operation of State Plans

Sec. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan [has been so changed that it] no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure.)

Definitions

Sec. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals not receiving aid or assistance under the State’s plan approved under title I, X, XIV, XV, or XVI, or part A of title IV, or *supplemental security income benefits under title XVI (as in effect after December 31, 1973)*, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV.

(iii) 65 years of age or older,

(iv) blind,

(v) 18 years of age or older and permanently and totally disabled, or

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving [aid or assistance under State plans approved under title I, X, XIV, XV, or XVI,] *benefits under title XX,*

but whose income and resources are insufficient to meet all of such cost—

¹ Effective with respect to services provided on or after July 1, 1973.

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4) (A) skilled nursing **[home]** facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;¹

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a skilled nursing **[home]** facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

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

(13) other diagnostic, screening, preventive, and rehabilitative services;

[(14) inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;]

*(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;*²

[(16)] (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902 (a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under 21, as defined in subsection (e);

[15] (17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary; except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for

¹ Effective Jan. 1, 1973.

² Applicable with respect to services furnished after Dec. 31, 1971.

any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases; [and]

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8) [, except that the Secretary shall promulgate such percentage as soon as possible after the enactment of this title, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1967].

(c) For purposes of this title the term "intermediate care facility" means an institution 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 nursing home is designed to provide, but who because of their mental or physical condition require care and services (above 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 established under regulation of the Secretary in addition to those applicable to nursing homes under State law. The term "intermediate care facility" also includes any skilled nursing home or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or mental defects.

(d) The term "intermediate care facility services" may include services in a public institution (or 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 health or rehabilitative services for mentally retarded individuals and which meet such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title 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 this title.]

(3) *the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institutions (or distinct parts thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.*

(e) *In the case of any State the State plan of which (as approved under this title)—*

(1) *does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but*

(2) *at a prior period did provide for the payment of services referred to in paragraph (1);*

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.¹

(f) *For purposes of this title, the term "skilled nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an in-patient basis.²*

(g) *If the State plan includes provision of chiropractors' services, such services include only—*

(1) *services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and*

(2) *services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.³*

(h) (1) *For purposes of paragraph (16) of subsection (a), the term*

¹ Applies to services performed on or after date of enactment.

² Applies to services furnished after Dec. 31, 1972.

³ Applies to services furnished after June 30, 1973.

“inpatient psychiatric hospital services for individuals under age 21” includes only—

(A) inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;

(B) inpatient services which, in the case of any individual, involves active treatment (which meets such standards, as may be prescribed pursuant to title XVIII in regulations by the Secretary) of such individual; and

(C) inpatient services which, in the case of any individual, are provided prior to (A) the date such individual attains age 21, or (B) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (i) the date such individual no longer requires such services, or (ii) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (c) (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

Advisory Council on Medical Assistance

[Sec. 1906. For the purpose of advising the Secretary on matters of general policy in the administration of this title (including the relationship of this title and title XVIII) and making recommendations for improvements in such administration, there is hereby created a Medical Assistance Advisory Council which shall consist of twenty-one persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, and a majority of the membership of the Advisory Council shall consist of representatives of consumers of health services. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and six at the end of the fourth year after the date of appointment. A member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Council or otherwise, appoint

such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of five or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.】¹

Observance of Religious Beliefs

Sec. 1907. Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

State Programs for Licensing of Administrators of Nursing Homes

Sec. 1908. (a) For purposes of section 1902(a)(29), a "State program for licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

(c) It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

¹ Repealed effective on the first day of the third calendar month following month of enactment.

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

[(d) No State shall be considered to have failed to comply with the provisions of section 1902(a)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who during all of the calendar year immediately preceding the calendar year in which the requirements prescribed in section 1902(a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such board pursuant to subsection (b)(1) other than such standards as relate to good character or suitability if—

(1) such waiver is for a period which ends after being in effect for two years or on June 30, 1972, whichever is earlier, and

(2) there is provided in the State (during all of the period for which waiver is in effect), a program of training and instruction designed to enable all individuals, with respect to whom any such waiver is granted, to attain the qualifications necessary in order to meet such standards.

(e)(1) There are hereby authorized to be appropriated for fiscal year 1968 and the four succeeding fiscal years such sums as may be necessary to enable the Secretary to make grants to States for the purpose of assisting them in instituting and conducting programs of training and instruction of the type referred to in subsection (d)(2).

(2) No grant with respect to any such program shall exceed 75 per centum of the reasonable and necessary cost, as determined by the Secretary, of instituting and conducting such program.]

(d) There are authorized to be appropriated for fiscal years 1973 and 1974 such sums as may be necessary to enable the Secretary to make grants to States for the purpose of assisting them in instituting and conducting programs of supplemental training and instruction for persons who are employed as administrators of intermediate care facilities in order to enable such administrators to comply with such standards as may be prescribed by the Secretary.

[(f)](e) For the purpose of advising the Secretary and the States

in carrying out the provisions of this section, there is hereby created a National Advisory Council on Nursing Home Administration which shall consist of nine persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include, but not be limited to, representatives of State health officers, State welfare directors, nursing home administrators, and university programs in public health or medical care administration.

(2) In addition to the function stated in paragraph (1) of this subsection, it shall be the function and duty of the Council (A) to study and identify the core of knowledge that should constitute minimally the training in the field of institutional administration which should qualify an individual to serve as a nursing home administrator; (B) to study and identify the experience in the field of institutional administration that a nursing home administrator should be required to possess; (C) to study and develop model techniques for determining whether an individual possesses such qualifications; (D) to study and develop model criteria for granting waivers under the provisions of subsection (d); (E) to study and develop suggested programs of training referred to in subsection (d); (F) to study, develop, and recommend programs of training and instruction for those desiring to pursue a career in nursing home administration; (G) to complete the functions in (A) through (E) above by July 1, 1969, and submit a written report to the Secretary which report shall be submitted to the States to assist them in carrying out the provisions of this section.

(3) Members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

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

(5) The Council shall be appointed by the Secretary prior to July 1, 1968, and shall cease to exist as of December 31, 1971.

[(g)](f) As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, *but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts*¹; and

(2) "nursing home administrator" means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such

¹ Effective on date of enactment.

home and whether or not his functions and duties are shared with one or more other individuals.

*Penalties*¹

Sec. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to 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 this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than 6 months, or both.

(d) For purposes of this section the word "whoever" includes corpo-

¹Not applicable to any acts, statements, or representations made or committed prior to enactment.

rations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals.

Certification and Approval of Skilled Nursing Facilities

Sec. 1910. (a) *The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State or local agencies (whichever are utilized by the Secretary pursuant to section 1864(a)) will be utilized by him for the purpose of determining whether an institution in such State qualifies as a skilled nursing facility for purposes of section 1902(a) (28). To the extent that the Secretary finds it appropriate, any institution which such a State or local agency certifies to him to be a skilled nursing facility may be treated as such by the Secretary.*

(b) *The Secretary shall advise the State agency administering the medical assistance plan of his approval or disapproval of any institution certified to him as a qualified skilled nursing facility for purposes of section 1902(a) (28) and specify for each such institution the period (not to exceed twelve months) for which approval is granted, except that the Secretary may extend such term for a period not exceeding two months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such twelve-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder. The State agency may enter into an agreement for the provision of services and the making of payments under the plan with any skilled nursing facility approved by the Secretary for a period not to exceed the period of approval specified.*

(c) *The Secretary may cancel the approval of any skilled nursing facility at any time if he finds that the skilled nursing facility fails to meet the requirements contained in section 1902(a) (28), or if he finds grounds for termination of his agreement with such institution pursuant to section 1866(b). In such event the Secretary shall notify the State agency and the skilled nursing facility that the approval of eligibility of such institution to participate in the programs established by this title and title XVIII shall be terminated at such time as may be specified by the Secretary. The approval of eligibility of any such institution to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.*

(d) *Effective July 1, 1973, no payment may be made to any State under this title with respect to skilled nursing facility services furnished by any institution—*

(1) *which does not have in effect an agreement with the State agency executed pursuant to subsection (b), or*

(2) *whose approval of eligibility to participate in the programs established by this title or title XVIII has been terminated by the Secretary and has not been reinstated, except that payment may be made for up to 30 days with respect to skilled nursing facility services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.*

**TITLE XX—FEDERAL GUARANTEED EMPLOYMENT
OPPORTUNITY PROGRAM FOR HEADS OF FAMILIES
WITH CHILDREN**

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**TITLE XX—FEDERAL GUARANTEED EMPLOYMENT
OPPORTUNITY PROGRAM FOR HEADS OF FAMILIES
WITH CHILDREN**

PART A—AUTHORIZATION OF APPROPRIATIONS

SEC. 2001. For the purpose of enabling families with children to achieve self-sufficiency through employment, by placing family heads in jobs in the regular economy or in guaranteed job opportunities with the Work Administration, and by providing child care and other services necessary for placement of family heads in such jobs, and for the purpose of making low-wage jobs more remunerative for family heads through a program of wage supplements, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this title.

**PART B—GUARANTEED EMPLOYMENT OPPORTUNITY,
WAGE SUPPLEMENT, AND INSTITUTIONAL TRAINING**

**SUBPART 1—GUARANTEED EMPLOYMENT
OPPORTUNITY**

Eligibility

SEC. 2010. (a) Every individual who is a head of family (as defined in section 2071(f)), who is a citizen of the United States (or an alien lawfully admitted for permanent residence in the United States or otherwise permanently residing in the United States under color of law), and who files an application in accordance with regulations prescribed by the Work Administration, shall (subject to subsection (b)) be eligible to be provided a job in guaranteed employment (as defined in section 2071(c)) in accordance with the provisions of this title.

(b)(1) No individual shall be placed in a job in guaranteed employment—

(A) for any week for which he is a substantially full-time student;

(B) for any week for which he receives unemployment compensation under any State or Federal unemployment compensation law;

(C) for any week with respect to which the family, of which such individual is the head, receives unearned income (as defined in section 2071(i)) of more than \$58;

(D) during any calendar year for which the family, of which such individual is the head, has received income of more than \$5,600, and during any period (consisting of not less than one

week) in which such family is receiving income at a rate of more than \$5,600 per year;

(E) if such individual has without good cause voluntarily left regular employment, for any week which begins within the 60-day period commencing on the date such individual so left such employment;

(F) if such individual has been discharged from regular employment for misconduct, for any week which begins (i) within the 60-day period commencing on the date such individual was so discharged, or (ii) within such longer period (which commences on such date but which shall not exceed 6 months) as the Work Administration shall prescribe in cases where an employee is discharged for gross or malicious misconduct;

(G) for any week for which such individual is unemployed on account of a labor dispute at the establishment where he was last employed, unless such individual (i) is not directly interested in and has not participated in such dispute, and (ii) is not a member of any group of employees which is directly interested in, financing, or participating in, such dispute;

(H) if such individual has refused to accept regular employment to which he was referred by the Work Administration, for any day—

(i) prior to the second day following the date he so refused to accept such employment (in case such individual has on only one occasion so refused to accept such employment);

(ii) during the 7-day period which commences on the date he last so refused to accept such employment (in case such individual has only on two occasions so refused to accept such employment); or

(iii) during the 30-day period which commences on the date he last so refused to accept such employment (in case such individual has on more than two occasions so refused to accept such employment).

(2) If any family receives unearned income on other than a weekly basis, the Work Administration shall, for purposes of paragraph (1) (C), allocate such income to such weeks as may be appropriate.

(3) No individual who leaves regular employment after having had approved by the Work Administration a petition to do so under subsection (c) shall, for purposes of paragraphs (1) (E) and (H), be considered, by reason of leaving such employment, to have left regular employment without good cause or to have refused to accept regular employment to which he was referred by the Work Administration.

(c) If any individual is dissatisfied with the job in regular employment to which he has been referred by the Work Administration he may, after having completed 30 days of service in such job, file with the Work Administration (in accordance with regulations prescribed by it) a petition to leave such job. If the Work Administration determines, in the case of any individual who has filed such a petition, that such job imposes a hardship on such individual or is not consistent with his skills and abilities, in light of the employment opportunities available in the area wherein such individual resides, it may approve such petition. Petitions under this subsection shall be considered in accordance with the provisions of section 2059 (d).

Work Assignments

SEC. 2011. (a) Every eligible individual (as prescribed in section 2010) shall be assigned work in guaranteed employment not later than the first day of the first workweek which begins after the date such individual's application to participate in guaranteed employment is approved by the Work Administration.

(b) In the case of a family which does not include any child under age 6, the work schedule for an eligible individual from such family, who is the mother of a child in such family (or, if there is no such mother in such family, is the father of a child in such family), shall be so arranged as not to require such individual to be at a worksite where he cannot supervise children in the family during hours that they are not in school unless—

(1) there is included among the members of the household of such individual a person (other than such eligible individual), who is capable of providing supervision for such children during such hours;

(2) an adult person (other than such eligible individual and such person) is available to provide supervision for such children during such hours; or

(3) child care is available for such children during such hours.

Hours of Work and Rate of Pay

SEC. 2012. (a) Each individual who is placed in guaranteed employment shall (except as is otherwise provided in subsection (c)) be provided the opportunity to work such number of hours per week (at a rate of pay equal to three-fourths the minimum wage, as defined in section 2071(d)), as may be required to enable him to earn \$48 per week.

(b) No individual shall be paid for any hour for which he does not actually perform (in accordance with the direction of his supervisor) the duties to which he is assigned (including child-care, household, and similar duties which he is assigned to perform at his own home).

(c) If during any week any eligible individual performs services (other than services performed under guaranteed employment) as an employee, the number of hours for which he would otherwise have the opportunity to work under guaranteed employment for such week shall be reduced by the number of hours he performs such services; except that, in determining the number of hours during any week for which such individual performs such services, the Work Administration may disregard not more than 20 hours if it determines that there is work available for such individual under guaranteed employment during the hours for which his workweek under guaranteed employment would otherwise be reduced.

Participants Not Employees

SEC. 2013. Participants in guaranteed employment shall not, by reason of the services performed by them in guaranteed employment, be considered to be employees within the meaning of any State law or any Federal law (other than this title) which defines, prescribes con-

ditions or limitations with respect to, or otherwise regulates, hours of work, rates of pay, or other conditions of employment, or which imposes any duty upon an employer with respect to his employees; and such participants shall not be entitled to any remuneration or benefits, on account of the performance of such services, other than the pay and benefits specifically authorized by this title.

Special Provisions for Puerto Rico

SEC. 2014. (a) Each individual in Puerto Rico who is placed in guaranteed employment shall (except as otherwise provided in section 2012(c)) be provided the opportunity to work each week for a number of hours equal to whichever of the following is the smaller: (1) 40, or (2) the number which, when multiplied by the rate of pay prescribed in subsection (b), produces \$48.

(b) The rate of pay for hours of work in guaranteed employment in Puerto Rico shall be equal to three-fourths of the lowest wage rate prescribed by an industry committee under section 5 of the Fair Labor Standards Act of 1938 (29 U.S.C. 205) which, when combined with all other lower industry committee rates for Puerto Rico, is applicable to at least 5 per centum of the total work force, in the Commonwealth of Puerto Rico, which is subject to the minimum wage rate under such Act.

SUBPART 2—EMPLOYMENT WITH WAGE SUPPLEMENT

Eligibility

SEC. 2030. Every individual who is a head of family (as defined in section 2071(f)) and is a citizen of the United States (or an alien lawfully admitted for permanent residence in the United States or otherwise permanently residing in the United States under color of law) and who—

(a) is employed in regular employment (as defined in section 2071(b)) in the United States (but not in the Commonwealth of Puerto Rico)—

(1) which is compensated at a rate which—

(A) is not less than the applicable rate (if any) required under Federal, State, or local law, and

(B) is less than (but not less than three-fourths of) the minimum wage (as defined in section 2071(d)), and

(2) in a position the compensation for which—

(A) has not, during the three-month period preceding the date on which such individual is placed in such position, been reduced, or (if such compensation has been reduced during such period) the Work Administration is satisfied (on the basis of evidence presented to it) that such compensation was not reduced in contemplation of the availability of the payment of wage supplement benefits under this subpart with respect to such position, and

(B) is not reduced during the period that such individual is employed in such position, unless (i) such

compensation is reduced after such individual has been employed in such position for a three-month period, or (ii) the Work Administration is satisfied (on the basis of evidence presented to it) that the reduction in such compensation is or was not made because of the availability of the payment of wage supplement benefits under this part with respect to such position;

(b) makes application (filed in such form and manner and with such official as may be prescribed under regulations prescribed by the Work Administration) for wage supplement benefits;

shall be entitled to receive the wage supplement payments authorized by this part for each week that the conditions of clauses (a) and (b) are met, commencing with the week following the week in which his application for such benefits is filed with the Work Administration.

Amount of Wage Supplement

SEC. 2031. (a) For each week any individual who is entitled to wage supplement benefits under this subpart shall be paid a wage supplement equal to the amount produced by multiplying (1) the number of hours (not in excess of 40) for which such individual performed services (whether or not for the same employer) in regular employment (which meets the requirements of section 2030(a)) by (2) three-fourths of the excess of (A) the minimum wage (as defined in section 2071(d)) over (B) the hourly wage (as defined in subsection (a)) paid or payable to such individual for the services performed by him in such employment.

(b) The term "wage", as used in subsection (a) (2) (B), shall have the meaning assigned to such term by section 3(m) of the Fair Labor Standards Act of 1938.

SUBPART 3—INSTITUTIONAL TRAINING

Eligibility

SEC. 2041. (a) Any individual who is eligible (under section 2010(a)) to be provided a job in guaranteed employment may volunteer to participate in the institutional training program established under section 2055.

Applications for Training

SEC. 2042. The Work Administration shall not approve the application of any individual for institutional training unless—

(a) the training involved can be completed within one year after it is commenced;

(b) the Work Administration determines that—

(1) such individual is capable of successfully completing such training, and

(2) successful completion of such training by such individual will enable him to secure a job in regular employment which is related to such training or to engage in self-employment which is related to such training.

Hours of Work and Training

SEC. 2043. (a) Any individual participating in institutional training shall for any week be entitled to be placed in a job in guaranteed employment for the hours in such week in which he is not engaged in such training; except that during no such week shall the—

- (1) number of hours during which he receives such training; plus*
- (2) the number of hours during which he performs services in regular and guaranteed employment; exceed 40 hours.*

Training Stipends

SEC. 2044. (a) Every individual participating in institutional training under this subpart shall be paid, on a weekly basis, a stipend equal to $\frac{5}{8}$ of the minimum wage (as defined in section 2071(d)) for each hour for which he (1) participates in such training, and (2) does not receive any other compensation.

(b) In addition, any such individual, upon the successful completion of institutional training, shall be paid an amount equal to 10 per centum of the total amount paid to him as stipends under subsection (a).

PART C—DUTIES OF WORK ADMINISTRATION

In General

SEC. 2051. (a) It shall be the duty and responsibility of the Work Administration to promote the economic self-sufficiency of families with children by providing to eligible heads of such families employment opportunities and the services necessary to take advantage of such opportunities.

(b) In carrying out the duty and responsibility imposed by subsection (a), the Work Administration shall—

(1) conduct a nationwide program to develop and promote new jobs for eligible heads of families with children, to identify unfilled jobs, and to place such family heads in such jobs;

(2) develop, in cooperation with State and local governments, projects to fill unmet public needs or otherwise to serve a useful public purpose;

(3) provide guaranteed job opportunities to carry out such projects and to furnish services necessary to enable such family heads to undertake employment;

(4) provide and arrange for child care and other supportive services necessary to enable such family heads to take advantage of employment opportunities;

(5) arrange transportation assistance where necessary to promote job opportunities in regular employment;

(6) provide training leading to jobs;

(7) provide to such family heads the benefits authorized under this title;

(8) perform such other functions as are necessary or appropriate to achieve the purposes of this title;

in accordance with the provisions of this title and utilizing, to the maximum extent feasible, eligible family heads to carry out such functions.

Job Development and Job Placement in the Regular Economy

SEC. 2052. (a) The Work Administration shall carry out a program to develop and solicit job opportunities for eligible family heads with children. In carrying out such program, the Work Administration shall cooperate closely with employers, employer groups, labor organizations, and other public and private organizations interested in job development programs, in each area of the Nation.

(b) The Work Administration shall, whenever possible, place an individual, who is an eligible applicant for or participant in guaranteed employment, in regular employment.

(c) The Work Administration, in carrying out its duties under this section, shall cooperate with and utilize the services of State agencies maintaining employment offices under the Wagner-Peyser Act (29 U.S.C. 49 et seq.) and any other public or nonprofit private manpower agencies or organizations; and all such agencies and organizations which are supported (wholly or in part) by Federal funds shall cooperate with the Work Administration in the carrying out of its duties under this section. The Work Administration is further authorized to take such other measures as it deems appropriate to facilitate the placement in regular employment of eligible family heads with children; except that the Work Administration shall not pay any fee or similar charge to any employment agency for its services in placing any individual in employment.

(d) To the maximum extent feasible, the Work Administration shall take account of each individual's education, prior work experience, aptitudes, and interests, with a view to assigning each individual to the available job opportunity for which he is most suited and which will be most likely to maximize the family income or otherwise best promote the well-being of his family.

(e) (1) In order to increase job opportunities, the Work Administration may enter into contracts with regular public or private employers under which—

(A) participants in guaranteed employment will be assigned, on a temporary basis, to provide services for or on behalf of such employers,

(B) such employers will pay to the Work Administration an amount equal to—

(i) the aggregate value of the wages and employment-related benefits to be provided to such participants, plus

(ii) a reasonable amount to compensate the Work Administration for expenses incurred in making the services of such participants available to such employers.

(2) The value of the wages (as referred to in paragraph (1)(B)(i)) attributable to any participant shall be computed on the basis of the prevailing wage (in the locality concerned) for the work to be performed by him, or, if higher, the wage rate (if any) which the employer, on whose behalf such work is to be performed, would be required to pay under applicable Federal, State, or local law, if such

participant performed such work as an employee of such employer. The value of employment-related benefits (as referred to in paragraph (1)(B)(i)) attributable to any participant shall be equal to those benefits (if any) prevailing (in the locality concerned) for work similar to that to be performed by him, or, if greater, those benefits (if any) which the employer, on whose behalf such work is to be performed, would be required under applicable Federal, State, or local law to provide to such participant, if such participant performed such work as an employee of such employer.

(3) (A) Any participant in guaranteed employment who is assigned, under a contract entered into under this subsection, to perform services for any employer shall receive (or have paid on his behalf), for the services performed by him for such employer, compensation equal to the value of the wages and employment-related benefits (as determined under paragraph (2)) attributable to the services performed by him.

(B) Subject to paragraph (3), in any case in which the Work Administration determines that it is impractical to provide in kind to a participant the employment-related benefits to which he is entitled under the preceding provisions of this subsection, the Work Administration may pay to such participant a dollar amount which it determines to be equivalent to the value of such benefits.

(4) The Work Administration shall certify to the Secretary of the Treasury (for purposes of the administration of the work bonus program established by chapter 97 of the Internal Revenue Code of 1954 and in accordance with such procedures as may be prescribed by the Secretary of the Treasury) with respect to each participant who performs, under a contract entered into under this subsection, services on behalf of any employer, any amount which—

(A) is paid by the Work Administration under this subsection to such participant to compensate him for the value of the wages attributable to the performance of such services by him,

(B) does not, and would not (if such services had been performed by such participant as an employee of such employer), constitute wages (within the meaning of section 209), and

(C) would (except for the provisions of section 209(g) (2) and (3), section 209(h) (2), and section 209(j)) constitute wages (within the meaning of section 209), if such services had been performed by such participant as an employee of such employer.

Guaranteed Job Program

SEC. 2053. (a) The Work Administration shall develop (whenever possible through arrangements with public and private nonprofit agencies and organizations) work projects, which serve a useful public purpose, to which participants in guaranteed employment will be assigned.

(b) The Work Administration shall not develop or participate in any work project, if the assignment of participants in guaranteed employment to work in such project would result in (1) the displacement of any regular employee who would otherwise be engaged in work on such project, or (2) in the performance of services which would otherwise be performed by regular employees.

(c) *The Work Administration shall, in assigning individuals to any work project in any State, comply with the laws of such State which regulate or restrict employment of minors.*

Child Care and Other Supportive Services

SEC. 2054. (a) (1) If any individual is eligible to participate in guaranteed employment and desires to participate in the employment and training program established by this title, the Work Administration shall (in case such individual is the head of a family headed by an employable person, within the meaning of section 411(g) (1) and (2)), and may (in case such individual is the head of any other family), provide directly or through arrangements with others (including arrangements by purchase) such child care and supportive services as may be necessary to enable such individual to participate in the employment and training program established by this title and to accept or retain a job in regular employment.

(2) Child care services provided by the Work Administration shall be provided by its Bureau of Child Care under title XXI.

(b) The Work Administration shall provide appropriate counseling for any employable mother (with no child under age 6) who is eligible to participate in guaranteed employment but who fails or refuses to do so, if her failure or refusal to do so is detrimental to welfare of the children in the family. During the period that she so fails or refuses to participate in guaranteed employment, the Work Administration may, for the period that such individual is receiving such counseling (but not for more than one month), make payments to such individual in an amount equal to the amount of the payments which would have been payable to such individual if she were participating full time in guaranteed employment.

Institutional Training

SEC. 2055. (a) The Work Administration is authorized to establish and conduct institutional training programs for individuals whose application for such training has been approved under section 2042; except that no such program shall involve any course of training which is greater in duration than one year.

(b) If any such individual can secure appropriate training under any program conducted by a public or nonprofit private agency (other than the Work Administration), the Work Administration shall refer such individual for training under such program, and in any such case, all of the costs of such training shall be borne by such other program.

Transportation Assistance

SEC. 2056. (a) Whenever the Work Administration determines that a job opportunity is available in regular employment for a participant in guaranteed employment, but that such participant is prevented from taking advantage of such opportunity because of the time required in commuting between his home and the worksite of such job is excessive in terms of the normal commuting time required for work in the labor market area, the Work Administration is authorized to make

such arrangements as are necessary to assist in reducing the commuting time for such participant to the normal commuting time required for work in the labor market area.

(b) The Work Administration, in providing any such transportation assistance to such participants shall (except in unusual circumstances where such assistance is necessary to provide job opportunities in regular employment for such participants) provide such assistance under arrangements whereby such participants or the employer or other person on whose behalf such participants provide services, assume all of the costs of providing such assistance.

Payments of Benefits

SEC. 2057. (a) (1) The Work Administration shall pay wage supplement benefits to individuals entitled thereto on a weekly basis.

(2) (A) The Work Administration shall, whenever it determines that it is appropriate to do so, enter into an agreement with a State, or with an agency administering the unemployment compensation law of a State, under which the State agency shall—

(i) pay, as agent of the Work Administration, wage supplement benefits to individuals who are entitled thereto and who reside in the State; and

(ii) otherwise carry out such administrative duties in connection with the payment of wage supplement benefits to such individuals as shall be specified in the agreement,

and the Work Administration shall pay to such agency (in advance or by way of reimbursement) for the reasonable and necessary costs incurred by the State agency in carrying out the agreement.

(B) Each such agreement shall provide the terms and conditions under which it may be amended or terminated; except that no such agreement shall be effective for any period after December 31, 1974.

(b) (1) (A) The Work Administration shall (subject to the succeeding sentence) pay to each eligible family head (as defined in paragraph (2)) who resides in a State, which has increased the amount of the aid (in the form of money payments) under its State plan (approved under part A of title IV) to compensate recipients of aid thereunder for the loss (by reason of the enactment of the Social Security Amendments of 1972) of eligibility for food stamps, an amount equal to the amount by which such aid has been increased to compensate for such loss, in the case of families (who are entitled to such aid) having the same family income and the same number of members as the number of family members in the family of such eligible family head. If the amount payable under the preceding sentence to any eligible family head for any month would cause the family total income (including such amount) of the family of which such family head is a member to exceed the amount of aid (in the form of money payments) under such State plan to a family (without other income or resources) of the same size as that of the family of such family head, then such amount shall be reduced (but not below zero) by an amount equal to the excess of the amount such income over the amount of such aid.

(B) Payments to which any eligible family head is entitled under subparagraph (A) shall be paid by the Work Administration on a monthly basis.

(2) For purposes of paragraph (1), the term "eligible family head" means an individual who—

(A) is a male individual who—

(i) is participating in guaranteed employment,

(ii) is participating in employment with wage supplement, or

(iii) will, for the calendar year involved, be eligible for payments under the work bonus program established by chapter 97 of the Internal Revenue Code of 1954; and

(B) is a member of a family the children of which would be eligible for aid under the State plan (approved under part A of title IV) of the State in which such individual resides except for the fact that they are not deprived of parental support or care due to the continued absence from the home of their father.

Development of Jobs With Work Administration

SEC. 2058. The Work Administration shall, in securing required personnel for the administration of this title, give priority to eligible applicants for or participants in guaranteed employment and to individuals who have successfully completed training provided under this title.

Factual Determinations

SEC. 2059. (a) Subject to subsection (b), the Work Administration shall make all factual determinations concerning any rights or claims of any individual to participate in or receive benefits under the employment and training program established by this title.

(b) (1) Nothing contained in subsection (a) shall be construed to preclude the Work Administration from delegating to a State the duty and power to make determinations respecting entitlement to and amount of wage supplement benefits, if an agreement with such State has been entered into under section 2057 (relating to State administration of wage supplement benefits) and such agreement provides for the delegation of such duty and power to such State.

(2) If any determination, concerning whether an individual has left employment without good cause or has been discharged for misconduct, has been made by a State agency administering a State law approved under section 3304 of the Internal Revenue Code of 1954 (relating to State unemployment compensation laws), the Work Administration shall adopt, as its own, such determination.

(c) No individual shall be disqualified from participation in guaranteed employment because he has refused to accept new work under any of the following conditions:

(A) if the position offered is vacant due directly to a strike, lockout, or other labor dispute,

(B) if the wages, hours, or other conditions of work offered are substantially less favorable to the individual than those prevailing for similar work in the locality, or

(C) if, as a condition of being employed, the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization.

(d) The Work Administration shall establish a panel, which shall include participants in guaranteed employment, to consider, and make recommendations to the Work Administration with respect to, any petition filed under section 2010(c).

Overpayments and Underpayments

Sec. 2060. Whenever the Work Administration finds that more or less than the correct amount of benefits has been paid by it with respect to any individual participating in the employment and training program established under this title, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments to such individual or by recovery from or payment to such individual (or by recovery from his estate). The Work Administration may suspend or waive the collection of any overpayment for good cause.

PART D—ESTABLISHMENT AND ORGANIZATION OF WORK ADMINISTRATION

Establishment and Organization

Sec. 2061. (a) There is hereby created a body corporate to be known as the Work Administration.

(b) (1) The powers and duties of the Work Administration shall be vested in a Board of Directors (hereinafter in this title referred to as the "Board") which shall consist of three members (not more than two of whom shall be members of the same political party), to be appointed by the President, by and with the advice and consent of the Senate.

(2) One member of the Board shall, at the time of his appointment, be designated by the President as the Chairman of the Board.

(3) Each member of the Board shall hold office for a term of three years, except that any member appointed to fill a vacancy which occurs prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the President at the time of appointment, one on June 30, 1974, one on June 30, 1975, and one on June 30, 1976.

(c) Vacancies in the membership of the Board shall not impair the powers of the remaining members of the Board to exercise the powers vested in, and to carry out the duties imposed upon, the Work Administration.

(d) Each member of the Board shall, during his tenure in office, devote his time and energies to the work of the Work Administration and shall not, during such tenure, engage in any other business or employment.

(e) (1) The Board shall have the power to appoint (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service) such personnel as it deems necessary to enable the Work Administration to carry out its functions under this title. All personnel shall be appointed solely on the ground of their fitness to perform their duties and without regard to political affiliation, sex, race, creed, or color. The Board may (without regard to the

provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates) fix the compensation of personnel. The amount of the compensation payable to any employee shall be reasonably related to the compensation payable to State employees performing similar duties in the State in which such employee is employed by the Work Administration; except that, in no case shall the amount of the compensation payable to any employee be greater than that payable to Federal employees performing similar services. For purposes of the preceding sentence, personnel employed in the principal office of the Work Administration shall be deemed to be performing services in the District of Columbia (which shall be deemed to be a State for such purposes), and personnel performing services in more than one State shall be deemed to be employed in the State in which their principal office or place of work is located.

(2) The Board is authorized to obtain the services of experts and consultants on a temporary or intermittent basis in accordance with the provisions of section 3109 of title 5, United States Code, but at rates not to exceed the per diem equivalent of the rate authorized for GS-18 by section 5332 of such title.

Duties and Powers

Sec. 2062. It shall be the duty and function of the Work Administration to establish and carry out (in accordance with the provisions of this title) the programs and activities authorized under this title, and the Work Administration, in carrying out its duties and functions, shall have the power—

(1) to adopt, alter, and use a corporate seal, which shall be judicially noticed;

(2) to adopt, amend, and repeal bylaws designed to enable it to carry out its duties and functions;

(3) in its corporate name, to sue and be sued, and to complain and to defend, in any court of competent jurisdiction (State or Federal), but no attachment, injunction, or similar process, mesne or final, shall be issued against the property of the Work Administration or against the Work Administration with respect to its property;

(4) to conduct its business in any State;

(5) to enter into and perform contracts, leases, cooperative agreements, or other transactions, on such terms as it may deem appropriate, with (i) any agency or instrumentality of the United States, (ii) any State, or any agency, instrumentality, or political subdivision thereof, or (iii) any other person or agency;

(6) to execute, in accordance with its bylaws, all instruments necessary or appropriate to the exercise of its powers;

(7) to acquire (by purchase, gift, devise, lease, or sublease), and to accept jurisdiction over and to hold and own, and dispose of by sale, lease, or sublease, real or personal property, or any interest therein, for its corporate purposes;

(8) to accept gifts or donations of services, or of property (whether real, personal, or mixed, or whether tangible or intangible), in aid of any of the purposes of this title;

(9) to enter into arrangements under which the Work Administration will, in carrying out its duties and functions, utilize (on a reimbursable or other basis) the services of any agency or program of the United States or of any State, or any political subdivision thereof;

(10) to study and evaluate its activities under this title; and

(11) to do any and all things necessary, convenient, or desirable, to carry out, in accordance with the provisions of this title, the programs, activities, duties, and functions authorized or required by this title.

Location of Offices

SEC. 2063. (a) The principal office of the Work Administration shall be located in the District of Columbia. For purposes of venue in civil actions, the Work Administration shall be deemed to be a resident of the District of Columbia.

(b) The Work Administration shall establish offices in each major urban area, and in such other areas as it deems to be necessary in order effectively to carry out its duties and functions.

Taxation

SEC. 2064. The Work Administration, its property, assets, and income shall be exempt from taxation of any and every type and form, whether imposed by the United States, or by any State, or any political subdivision thereof.

Reports to Congress

SEC. 2065. The Work Administration shall not later than January 30, 1975, and not later than January 30 of each year thereafter, submit to the Congress a full and complete written report on its activities during the preceding calendar year. There shall be included in such report such data and information as may be required fully to apprise the Congress of the action (if any) which the Work Administration has taken to improve the employment and training program conducted by the Work Administration, together with a statement regarding the future plans (if any) of the Work Administration to improve such program.

Applicability of Other Laws

SEC. 2066. (a) Except as is otherwise provided in this part, the Work Administration, as a wholly owned Government corporation, shall be subject to the Government Corporation Control Act (31 U.S.C. 841-871).

(b) The provisions of section 3648 of the Revised Statutes as amended (31 U.S.C. 529), relating to advances of public moneys and certain other payments, shall not be applicable to the Work Administration.

(c) The provisions of section 3709 of the Revised Statutes, as amended (41 U.S.C. 5), or other provisions of law relating to competitive bidding, shall not be applicable to the Work Administration.

(d) Except as otherwise provided in this title, all Federal laws dealing generally with agencies of the United States shall be deemed to be

applicable to the Work Administration, and all laws dealing generally with officers and employees of the United States shall be deemed to be applicable to officers and employees of the Work Administration (but not to individuals providing services to the Work Administration while they are participants in the employment and training program established pursuant to this title).

(e) All general Federal penal statutes relating to larceny, embezzlement, conversion, or to the improper handling, retention, use, or disposal of moneys or property of the United States shall apply to moneys and property of the Work Administration.

Collection and Publication of Statistical Data

SEC. 2067. The Work Administration shall collect, classify, and publish, on a monthly and annual basis, statistical data relating to its operations and the number of individuals participating in the employment and training program conducted by the Work Administration, the number of participants in each type of employment or training provided under the program, and such other data as may be relevant in indicating the type, kind, and extent of the functions performed and services provided by the Work Administration.

National Advisory Council

SEC. 2068. (a) (1) For the purpose of providing advice and recommendations for the consideration of the Board in matters of general policy of the Work Administration in carrying out its purposes and functions, and with respect to improvements in the administration by the Work Administration of the provisions of this title, there is hereby created a Work Administration National Advisory Council (hereinafter in this title referred to as the "National Advisory Council").

(2) The National Advisory Council shall be composed of the twelve individuals, who shall be appointed by the Board (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service), and who are not otherwise in the employ of the United States.

(3) The members of the National Advisory Council shall be so selected as to include representatives of private industry, labor organizations, State and local governments, nonprofit organizations which provide employment, social service organizations, and minority groups.

(b) Each member of the National Advisory Council shall hold office for a term of three years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Board at the time of appointment, four at the end of one year after the date on which they were appointed, four at the end of two years after the date on which they were appointed, and four at the end of three years after the date on which they were appointed.

(c) The National Advisory Council is authorized to engage such technical assistance as may be required to enable it to carry out its

functions, and the Board shall, in addition, make available to the National Advisory Council such secretarial, clerical and other assistance and such pertinent data prepared by the Work Administration as such Council may require to carry out its functions.

(d) Members of the Council shall, while serving on the business of the Council, be entitled to receive compensation at the rate of \$100 per day, including traveltime; and while serving away from their homes or regular places of business, they shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

Local Advisory Councils

SEC. 2069. (a) The Work Administration shall establish in each geographic area served by an office of the Work Administration, a Work Administration Local Advisory Council (hereinafter in this title referred to as a "Local Advisory Council").

(b) It shall be the duty and function of each Local Advisory Council, within the geographic area with respect to which it is established, to identify and advise the local office of the Corporation of the job openings available or likely to become available in such area, and to encourage the establishment and development of job opportunities within such area for individuals who reside in such area and who are participating in the employment and training program established under this title.

(c) (1) Members of any Local Advisory Council shall be residents of the geographic area with respect to which such Council is appointed.

(2) The members of each Local Advisory Council shall (A) be so selected as to include representatives of private industry, labor organizations, State or local governments, nonprofit organizations which provide employment, social service organizations, and minority groups, and (B) serve without compensation.

PART E—DEFINITIONS

Definitions

SEC. 2071. For purposes of this title—

(a) The term "Work Administration" means the administrative body established under section 2061.

(b) The term "regular employment" means any employment provided by a private or public employer, but does not include guaranteed employment.

(c) The term "guaranteed employment" means employment provided (in accordance with the provisions of this title) by the Work Administration, but does not include employment by such Administration at a rate in excess of that specified in section 2012.

(d) The term "minimum wage" means the hourly wage rate specified in section 6(a) (1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a) (1)), or \$2.00 per hour, whichever is less.

(e) The term "family" means two or more individuals—

(1) each of whom (in the case of adult individuals) is the

parent (or stepparent), grandparent (or stepgrandparent), brother (or stepbrother), sister (or stepsister), uncle, aunt, first cousin, nephew, or niece, of a child referred to in clause (2);

(2) at least one of whom is a child who is in the care of or dependent upon another of such individuals who bears to such child one of the relationships specified in clause (1); and

(3) who are living in a place of residence in the United States maintained by one or more of them as his or their own home, except that no child who is living away from home while attending school shall, by reason of clause (4), be excluded as a member of a family on account of his absence from the family residence.

(f) The term "head of family", when used in reference to any family, means—

(1) in case there is included among the members of the family an individual, who is the father of a child who is a member of the family, such individual (unless he is disabled);

(2) in case there is no individual in the family who meets the criteria specified in clause (1) and there is included among the members of the family an individual, who is the mother of a child who is a member of the family, such individual (unless she is disabled);

(3) in case there is no individual in a family who meets the criteria specified in clause (1) or (2), any other individual who is member of such family (other than a child or an individual who is disabled) and who undertakes to provide for the support of the children who are members of such family: except that (A) not more than one such individual shall, at any time, be regarded as the head of family of the family of which he is a member, and (B) no such individual shall be regarded as the head of family of any family if the Work Administration determines that there is no child in such family other than a child which has been placed in such family in order to enable a member thereof to participate in the employment and training program established under this title.

(g) The term "child" means an individual who is unmarried and who—

(1) has not attained the age of 18; or

(2) has attained such age but has not attained the age of 21 and is a "full-time student" (as such term is applied for purposes of section 202(d)).

(h) The term "disabled", when used in reference to any individual, means the inability of such individual to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment.

(i) The term "unearned income" includes—

(1) any payments received as an annuity, pension, retirement, or disability benefit (including veterans' compensation and pensions, workmen's compensation payments, monthly insurance benefits under title II, railroad retirement annuities and pensions, and benefits under any Federal or State unemployment compensation law);

(2) prizes and awards;

(3) *the proceeds of any life insurance policy to the extent that they exceed the amount expended by members of the family concerned for expenses of the insured individual's last illness and burial;*

(4) *gifts (cash or otherwise), support and alimony payments; and*

(5) *rents, dividends, interest, and royalties.*

(j) *The term "United States", when used in a geographic sense, means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.*

TITLE XXI—CHILD CARE

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Findings and Declaration of Purpose

SEC. 2101. (a) *The Congress finds and declares that—*

(1) *the present lack of adequate child care services is detrimental to the welfare of families and children in that it limits opportunities of parents for employment or self-improvement, and often results in inadequate care arrangements for children whose parents are unable to find appropriate care for them;*

(2) *low-income families and dependent families are severely handicapped in their efforts to attain or maintain economic independence by the unavailability of adequate child care services;*

(3) *many other families, especially those in which the mother is employed, have need for child care services, either on a regular basis or from time to time; and*

(4) *there is presently no single agency or organization, public or private, which is carrying out the responsibility of meeting the Nation's needs for adequate child care services.*

(b) *It is therefore the purpose of this title to promote the availability of adequate child care services throughout the Nation by providing for the establishment of a Bureau of Child Care which shall have the responsibility and authority to meet the Nation's unmet needs for adequate child care services, and which, in meeting such needs, will give special consideration to the needs for such services by families in which the mother is employed or preparing for employment, and will promote the well-being of all children by assuring that the child care services provided will be appropriate to the particular needs of the children receiving such services.*

Establishment and Organization of Bureau of Child Care

SEC. 2102. (a) In order to carry out the purposes of this title, there is hereby established as a division of the Work Administration (established under title XX of this Act) a Bureau of Child Care (hereinafter in this title referred to as the "Bureau").

(b) (1) The powers and duties of the Bureau shall be vested in a Director who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) The Director shall have the power to appoint (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service) such personnel as he deems necessary to enable the Bureau to carry out its functions under this title. All personnel shall be appointed solely on the ground of their fitness to perform their duties and without regard to political affiliation, sex, race, creed, or color. The Director may (without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates) fix the compensation of personnel. The amount of the compensation payable to any employee shall be reasonably related to the compensation payable to State employees performing similar duties in the State in which such employee is employed by the Bureau; except that, in no case shall the amount of the compensation payable to any employee be greater than that payable to Federal employees performing similar services. For purposes of the preceding sentence, personnel employed in the principal office of the Bureau shall be deemed to be performing services in the District of Columbia (which shall be deemed to be a State for such purposes), and personnel performing services in more than one State shall be deemed to be employed in the State in which their principal office or place of work is located.

(3) The Director is authorized to obtain the services of experts and consultants on a temporary or intermittent basis in accordance with the provisions of section 3109 of title 5, United States Code, but at rates for individuals not to exceed the per diem equivalent of the rate authorized for GS-18 by section 5332 of such title.

(4) The Director shall establish, within the Bureau, an Office of Program Evaluation and Auditing the functions of which shall be to assure that standards established under this title with respect to child care services and facilities providing such services will be met, and that funds of or under the control of the Bureau will be properly used. The Director shall utilize such Office to carry out the duties (relating to evaluation of facilities) imposed upon him under section 2104(c) (2).

Duties and Powers

SEC. 2103. (a) It shall be the duty and function of the Bureau to meet the needs of the Work Administration for child care services and, to the maximum extent economically feasible, the needs of the Nation for child care services.

(b) (1) In carrying out such duty and function, the Bureau shall, through utilization of existing facilities for child care and otherwise, provide (or arrange for the provision of) child care services in the various communities of each State. Such child care services shall in-

clude the various types of care included in the term "child care services" (as defined in section 2118(b)) to the extent that the needs of the various communities may require.

(2) The Bureau shall charge and collect a reasonable fee for the child care services provided by it (whether directly or through arrangements with others). The fee so charged for any particular type of child care services provided in any facility shall be uniform for all children receiving such types of services in such facility. Any such fee so charged may be paid in whole or in part by any person (including the Bureau, as provided in subsection (e)), or any other public agency) which agrees to pay such fee or a part thereof.

(3) The Bureau shall not enter into any arrangement with any person under which the facilities or services of such person will be utilized by the Bureau to provide child care services unless such person agrees (A) to accept any child referred to such person by the Bureau for child care services on the same basis and under the same conditions as other children applying for such services, and (B) to accept payment of all or any part of the fee imposed for such services from any public agency which shall agree to pay such fee or a part thereof from Federal funds.

(c) In providing child care services in the various communities of the Nation, the Bureau shall accord first priority (1) to the needs for child care services of families on behalf of whom child care services will be paid in whole or in part from funds appropriated to carry out title XX and section 2109 of this title and who are in need of such services to enable a member thereof to accept or continue in employment or participate in training to prepare such member for employment, and (2) to arranging for care in facilities providing hours of child care sufficient to meet the child care needs of children whose mothers are employed full time.

(d) In providing for child care services the Bureau shall first place children in facilities which receive funds from sources other than funds made available under this title including, if the parents of such children agree, child development programs.

(e) (1) From the sums available to carry out the provisions of this title for each fiscal year, the Bureau is authorized to assist low-income families in meeting the costs of child care services where such services are necessary to enable an adult member of such family to engage in employment.

(2) The amount of the subsidy provided to any family under this subsection shall be determined in accordance with a schedule established by the Director, after taking into account the number of families needing such assistance, the amount of assistance needed by such families, and the amount of the funds available for the provision of such assistance. Such schedule shall (A) provide that the amount of subsidy payable to any family shall be equal to a per centum of the costs incurred by such family for the child care services with respect to which such subsidy is paid, (B) be related to ability of such family to pay the costs of such services (as determined by family size and income), and (C) be designed to assure that the amount of the subsidy payable to any family is not greater than the minimum amount necessary to enable such family to secure such services.

(f) In carrying out its duties and functions under this title, the Bureau shall have, in addition to the powers it has as a division of the Work Administration, power—

(1) to acquire (by purchase, gift, devise, lease, or sublease), and to accept jurisdiction over and to hold and own, and dispose of by sale, lease, or sublease, real or personal property, including but not limited to a facility for child care, or any interest therein for its purposes;

(2) to operate, manage, superintend, and control any facility for child care under its jurisdiction and to repair, maintain, and otherwise keep up any such facility; and to establish and collect fees, rentals, or other charges for the use of such facility or the receipt of child care services provided therein;

(3) to provide child care services for the public directly or by agreement or lease with any person, agency, or organization, and to make rules and regulations concerning the handling of referrals and applications for the admission of children to receive such services; and to establish and collect fees and other charges, including reimbursement allowances, for the provision of child care services: Provided, That, in determining how its funds shall be used for the provision of child care services within a community, the Bureau shall take into account any comprehensive planning for child care which has been done, and shall generally restrict its direct operation of programs to situations in which public or private agencies are unable to develop adequate child care;

(4) to provide advice and technical assistance to persons desiring to enter into an agreement with the Bureau for the provision of child care services to assist them in developing their capabilities to provide such services under such an agreement;

(5) to prepare, or cause to be prepared, plans, specifications, designs, and estimates of costs for the construction and equipment of facilities for child care services in which the Bureau provides child care directly;

(6) to construct and equip, or by contract cause to be constructed and equipped, facilities (other than home child care facilities) for child care services: Provided, That the Bureau shall take into account any comprehensive planning for child care that has been done;

(7) to train persons for employment in providing child care services, with particular emphasis on training participants in the employment program under title XX;

(8) to procure insurance, or obtain indemnification, against any loss in connection with the assets of the Bureau or any liability in connection with the activities of the Bureau, such insurance or indemnification to be procured or obtained in such amounts, and from such sources, as the Board deems to be appropriate;

(9) to cooperate with any organization, public or private, the objectives of which are similar to the purposes of this title; and

(10) to do any and all things necessary, convenient, or desirable to carry out the purposes of this title, and for the exercise of the powers conferred upon the Bureau in this title.

Standards for Child Care

SEC. 2104. (a) *In order to assure that adequate standards of staffing, health, sanitation, safety, and fire protection are met, the Bureau shall not provide or arrange for the provision of child care of any type or in any facility unless the applicable requirements set forth in the succeeding provisions of this section are met with respect to such care and the facility in which such care is offered.*

(b) (1) *The ratio of the number of children receiving child care to the number of qualified staff members directly engaged in providing such care (whether as teachers' aids or in another capacity) shall be such as the Director may determine to be appropriate for the type of child care provided and the age of the children involved, but in no case shall the Director require a ratio of less than—*

(A) *eight to one, in case such care is provided in a home child care facility; or*

(B) *ten to one, in case such care is provided in a day nursery facility, nursery school, child development center, play group facility, or preschool child care center.*

For purposes of applying the ratios set forth in clauses (A) and (B) of the preceding sentence, any child under age three shall be considered as two children.

(2) *In the case of any facility (other than a facility to which paragraph (1) is applicable) the ratio of the number of children receiving child care therein to the number of qualified staff members providing such care shall not be greater than such ratio as the Director may determine to be appropriate to the type of child care provided and the age of the children involved, except that such ratio shall not be greater than twenty-five to one.*

(3) *As used in this subsection, the term "qualified staff member" means an individual who has received training in, or demonstrated ability in, the care of children.*

(c) (1) *Any facility in which the Bureau provides child care (whether directly or through arrangements with others) must—*

(A) (i) *in the case of facilities that are not homes, meet such provisions of the Life Safety Code of the National Fire Protection Association (Twenty-first edition, 1967) as are applicable to the type of facility; except that the Bureau may waive for such periods as it deems appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the Bureau makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the children receiving care in such facility and (ii) in the case of facilities that are homes, meet requirements adopted by the local area (or a comparable area, if none have been adopted for the local area) for application to general residential occupancy;*

(B) *contain (or have available to it for use) adequate indoor and outdoor space for children for the number and ages of the children served by such facility; have separate rooms or areas for cooking, and have separate rooms for toilets;*

(C) have floors and walls of a type which can be cleaned and maintained and which contain or are covered with no substance which is hazardous to the health or clothing of children;

(D) have such ventilation and temperature control facilities as may be necessary to assure the safety and reasonable comfort of each child receiving care therein;

(E) provide safe and comfortable facilities for the variety or activities children engage in while receiving care therein;

(F) provide special arrangements or accommodations, for children who become ill, which are designed to provide rest and quiet for ill children while protecting other children from the risk of infection or contagion; and

(G) make available to children receiving care therein such toys, games, books, equipment, and other material as are appropriate to the type of facility involved and the ages of the children receiving care therein.

(2) The Director, in determining whether any particular facility meets minimum requirements imposed by paragraph (1) of this subsection, shall evaluate, not less often than once each year, on the basis of inspections made by personnel employed by the Bureau or by others through arrangements with the Bureau, such facility separately and shall make a determination with respect to such facility after taking into account the location and type of care provided by such facility as well as the age group served by it.

(d) The Bureau shall not provide (directly or through arrangements with other persons) child care in a child care facility or home child care facility unless—

(1) such facility requires that, in order to receive child care provided by such facility, a child must have been determined by a physician (after a physical examination) to be in good health and must have been immunized against such diseases and within such prior period as the Director may prescribe in order adequately to protect the children receiving care in such facility from communicable disease (except that no child seeking to enter or receiving care in such a facility shall be required to undergo any medical examination, immunization, or physical evaluation or treatment (except to the extent necessary to protect the public from epidemics of contagious diseases) if his parent or guardian objects thereto in writing on religious grounds);

(2) such facility provides for the daily evaluation of each child receiving care therein for indications of illness;

(3) such facility provides adequate and nutritious (though not necessarily hot) meals and snacks, which are prepared in a safe and sanitary manner;

(4) such facility has in effect procedures designed to assure that each staff member thereof is fully advised of the hazards to children of infection and accidents and is instructed with respect to measures designed to avoid or reduce the incidence or severity of such hazards;

(5) such facility has in effect procedures under which the staff members of such facility (including voluntary and part-time staff members) are required to undergo, prior to their initial employ-

ment and periodically thereafter, medical assessments of their physical and mental competence to provide child care;

(6) such facility keeps and maintains adequate health records on each child receiving care in such facility and on each staff member (including any voluntary or part-time staff member) of such facility who has contact with children receiving care in such facility; and

(7) such facility has in effect, for the children receiving child care services provided by such facility, a program under which emergency medical care or first aid will be provided to any such child who sustains injury or becomes ill while receiving such services from such facility, the parent of such child (or other proper person) will be promptly notified of such injury or illness, and other children receiving such services in such facility will be adequately protected from contagious disease.

(e) The Bureau shall not provide (directly or through arrangements with other persons) child care, in any child care facility or home child care facility, to any child unless there is offered to the parent or parents with whom such child is living (or, if such child is not living with a parent, the guardian or other adult person with whom such child is living) the opportunity of (A) meeting and consulting, from time to time, with the staff of such facility on the development of such child, and (B) observing, from time to time, such child while he is receiving care in such facility.

(f) Any nursery school, kindergarten, or child development center in which care is provided must meet applicable State or local educational standards.

Physical Structure and Location of Child Care Facilities

SEC. 2105. (a) There may be utilized, to provide child care authorized by this title, new buildings especially constructed as child care facilities, as well as existing buildings which are appropriate for such purpose (including, but not limited to, schools, churches, social centers, apartment houses, public housing units, office buildings, and factories).

(b) The Director, in selecting the location of any facility to provide child care under this title, shall, to the maximum extent feasible, give consideration to such factors as whether the site selected therefor—

(1) is conveniently accessible to the children to be served by such facility, in terms of distance from the homes of such children as well as the length of traveltime (on the part of such children and their parents) involved;

(2) is sufficiently accessible from the place of employment of the parents of such children so as to enable such parents to participate in such programs, if any, as are offered to parents by such facility; and

(3) is conveniently accessible to other facilities, programs, or resources which are related to, or beneficial in, the development of the children of the age group served by such facility.

Exclusiveness of Federal Standards; Penalty for False Statement or Misrepresentation

Sec. 2106. (a) Any facility in which child care services are provided by the Bureau (whether directly or through arrangements with other persons) shall not be subject to any licensing or similar requirements imposed by any State (or political subdivisions thereof), and shall not be subject to any health, fire, safety, sanitary, or other requirements imposed by any State (or political subdivision thereof) with respect to facilities providing child care.

(b) If any State (or political subdivision thereof), group, organization, or individual feels that the standards imposed, or proposed to be imposed, by the Bureau under section 2104(c)(1) for child care facilities (or any type of class of child care facilities) are less protective of the welfare of children than those imposed on such facilities by such State (or political subdivision thereof, as the case may be), such State (or political subdivision thereof), group, organization, or individual may, by filing a request with the Bureau, obtain a hearing on the matter of the standards imposed or proposed to be imposed by the Bureau with respect to such facilities.

(c) Whoever knowingly and willfully makes or causes to be made, or induced or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any facility in order that such facility may qualify as a facility in which child care services are provided by the Bureau (whether directly or through arrangements with other persons) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than six months, or both, and any such facility shall be ineligible, for two years following such conviction, to participate in any child care program that is in whole or in part funded by the United States.

Reconsideration of Certain Decisions

Sec. 2107. Whenever any group or organization has presented to the Bureau a proposal, under which such group or organization would provide child care services on behalf of the Bureau, which has been rejected by the Bureau, such group or organization, upon request filed with the Director may have a reconsideration of such proposal by the Bureau.

Confidentiality of Certain Information

Sec. 2108. The Bureau shall impose such safeguards with respect to information held by it concerning applicants for and recipients of child care as are necessary or appropriate to assure that such information will be used only for purposes directly connected with the administration of this title, that the privacy of such applicants or recipients will be protected, and that, when such information is used for statistical purposes, it will be used in such manner as not to identify the particular individuals involved.

Authorization of Appropriations

Sec. 2109. In addition to such sums as may be available to the Bureau from the Child Care Fund established under section 2110, there is hereby authorized to be appropriated to carry out the provisions of this title, for the fiscal year beginning July 1, 1972, the sum of \$800,000,000, and for each fiscal year thereafter, such sums as may be necessary.

Revolving Fund

Sec. 2110. (a) There is hereby established in the Treasury a revolving fund to be known as the Federal Child Care Fund (hereinafter in this title referred to as the "Fund") which shall be available to the Bureau without fiscal year limitation to carry out its purposes, functions, and duties under this title.

(b) There shall be deposited in the Fund—

(1) funds appropriated under section 2109; and

(2) the proceeds of all fees, rentals, charges, interest, or other receipts (including gifts) received by the Bureau.

(c) Except for expenditures from the Federal Child Care Capital Fund (established by section 2111(d)) and expenditures from appropriated funds, all expenses of the Bureau (including salaries and other personnel expenses) shall be paid from the Fund.

(d) If the Bureau determines that the moneys in the fund are in excess of the current needs of the Bureau, it may invest such amounts therefrom as it deems advisable in obligations of the United States or obligations the payment of principal and interest of which is guaranteed by the United States.

Revenue Bonds of Bureau

Sec. 2111. (a) The Bureau is authorized (after consultation with the Secretary of the Treasury) to issue and sell bonds, notes, and other evidences of indebtedness (hereafter in this section collectively referred to as "bonds") whenever the Director determines that the proceeds of such bonds are necessary, together with other moneys available for operation of the Bureau from the Fund, to provide funds sufficient to enable the Bureau to carry out its purposes and functions under this title with respect to the acquisition, planning, construction, remodeling, or renovation of facilities for child care or sites for such facilities; except that (1) no such bonds shall be sold prior to July 1, 1975, (2) no more than \$50,000,000 of such bonds shall be issued and sold during any fiscal year, and (3) the outstanding balance of all bonds so issued and sold shall not at any one time exceed \$250,000,000.

(b) Any such bonds may be secured by assets of the Bureau, including, but not limited to, fees, rentals, or other charges which the Bureau receives for the use of any facility for child care which the Bureau owns or in which the Bureau has an interest. Any such bonds are not, and shall not for any purpose be regarded as, obligations of the United States.

(c) Any such bonds shall bear such rate of interest, have such dates of maturity, be in such denominations, be in such form, carry such registration privileges, be executed in such manner, be payable

on such terms, conditions, and at such place or places, and be subject to such other terms and conditions, as the Director may prescribe.

(d) (1) There is hereby established in the Treasury a fund to be known as the "Federal Child Care Capital Fund" (hereinafter in this title referred to as the "Capital Fund"), which shall be available to the Bureau without fiscal year limitations to carry out the purposes and functions of the Bureau with respect to the acquisition, planning, construction, remodeling, renovation, or initial equipping of facilities for child care services, or sites for such facilities.

(2) The proceeds of any bonds issued and sold pursuant to this section shall be deposited in the Capital Fund and shall be available only for the purposes and functions referred to in paragraph (1) of this subsection.

Collection and Publication of Statistical Data

Sec. 2112. The Bureau shall collect, classify, and publish, on a monthly and annual basis, statistical data relating to its operation and child care provided (directly or indirectly) by the Bureau together with such other data as may be relevant to the purposes and functions of the Bureau.

Reports to Congress

Sec. 2113. (a) The Director shall, not later than January 30 following the close of the first session of each Congress (commencing with January 30, 1974), submit to the Congress a written report on the activities of the Bureau during the period ending with the close of the session of Congress last preceding the submission of the report and beginning, in the case of the first such report so submitted, with the date of enactment of this title, and in the case of any such report thereafter, with the day after the last day covered by the last preceding report so submitted. As a separate part of any such report, there shall be included such data and information as may be required fully to apprise the Congress of the actions which the Bureau has taken to improve the quality and availability of child care services, together with a statement regarding the future plans (if any) of the Bureau to further improve the quality of such services.

(b) The Director shall conduct, on a continuing basis, a study of the standards for child care under section 2104, and shall report to the Congress, not later than January 1, 1977, the results of such study, together with his recommendations (if any) with respect to changes which should be made in establishing such standards.

Applicability of Other Laws

Sec. 2114. (a) Except as otherwise provided in this title, the Bureau shall be subject to such laws as are applicable to the Work Administration established under title XX.

(b) The provisions of section 3709 of the Revised Statutes, as amended (41 U.S.C. 5), or other provisions of law relating to competitive bidding, shall not be applicable to the Bureau; nor shall any other provision of law limiting the authority of instrumentalities of the United States to enter into contract be applicable to the Bureau

in respect to contracts entered into by the Bureau for the provision of child care services in a home child care facility, temporary child care home, or a night care home.

(c) The provisions of the Public Buildings Act of 1959 (40 U.S.C. 601-615) shall not apply to the acquisition, construction, remodeling, renovation, alteration, or repair of any building of the Bureau or to the acquisition of any site for any such building for use as a child care facility.

Research and Demonstrations

SEC. 2115. The Secretary, in the administration of section 426, shall consult with and cooperate with the Bureau with a view to providing for the conduct of research and demonstrations which will be applicable to child care services.

National Advisory Council on Child Care

SEC. 2116. (a) (1) For the purpose of providing advice and recommendations for the consideration of the Director of the Bureau in matters of general policy in carrying out the purposes and functions of the Bureau, and with respect to improvements in the administration by the Bureau of its purposes and functions, there is hereby created a National Advisory Council on Child Care (hereinafter in this section referred to as the "Council").

(2) The Council shall be composed of the Secretary of Health, Education, and Welfare, the Secretary of Labor, the Secretary of Housing and Urban Development, and eight individuals, who shall be appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service), and who are not otherwise in the employ of the United States.

(3) Of the appointed members of the Council, not more than three shall be selected from individuals who are representatives of social workers or child welfare workers or nonprofit organizations or are from the field of education, and the remaining appointed members shall be selected from individuals who are representatives of consumers of child care (but not including more than one individual who is a representative of any organization which is composed of or represents recipients of such assistance).

(b) Each appointed member of the Council shall hold office for a term of three years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his successor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the appointed members first taking office shall expire, as designated by the Director at the time of appointment, four on June 30, 1974, four on June 30, 1975, and four on June 30, 1976.

(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Director shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Bureau as the Council may require to carry out its functions.

(d) *Appointed members of the Council shall, while serving on the business of the Council, be entitled to receive compensation at the rate of \$100 per day, including traveltime; and while so serving away from their homes or regular places of business, they shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.*

Cooperation With Other Agencies

SEC. 2117. (a) (1) The Bureau is authorized to enter into agreements with public and other nonprofit agencies or organizations whereby children receiving child care provided by the Bureau (whether directly or through arrangements with other persons) will be provided other services conducive to their health, education, recreation, or development.

(2) Any such agreement with any such agency or organization shall provide that such agency or organization shall pay the Bureau in advance or by way of reimbursement, for any expenses incurred by it in providing any services pursuant to such agreement.

(b) The Bureau may also enter into cooperative arrangements with the State health authority and the State agency primarily responsible for State supervision of public schools to utilize such agencies in the provision of health services and education for children receiving child care.

Definitions

SEC. 2118. For purposes of this title—

(a) The term "Bureau" means the Bureau of Child Care established pursuant to section 2102.

(b) The term "child care services" means the provision, by the person undertaking to care for any child, of such personal care, protection, and supervision of each child receiving such care as may be required to meet the child care needs of such child, including services provided by—

- (1) a child care facility;*
- (2) a home child care facility;*
- (3) a temporary child facility;*
- (4) an individual as a provider of at-home child care;*
- (5) a night care facility; or*
- (6) a boarding facility.*

(c) The term "child care facility" means any of the following facilities:

- (1) day nursery facility;*
- (2) nursery school;*
- (3) kindergarten;*
- (4) child development center;*
- (5) play group facility;*
- (6) preschool child care center;*
- (7) school age child care center;*
- (8) summer day care program facility;*

but only if such facility offers child care services to not less than six children; and in the case of a kindergarten, nursery school, or other

daytime program, such facility is not a facility which is operated by a public school system, and the services of which are generally available without charge throughout a school district of such system.

(d) *The term "home child care facility" means—*

- (1) *a family day care home;*
- (2) *a group day care home;*
- (3) *a family school day care home; or*
- (4) *a group school age day care home.*

(e) *The term "temporary child care facility" means—*

- (1) *a temporary child care home;*
- (2) *a temporary child care center; or*
- (3) *other facility (including a family home, or extended or modified family home) which provides care, on a temporary basis, to transient children.*

(f) *The term "at-home child care" means the provision, to a child in his own home, of child care services, by an individual, who is not a member of such child's family or a relative of such child, while such child's parents are absent from the home.*

(g) *The term "night care facility" means—*

- (1) *a night care home;*
- (2) *a night care center; or*
- (3) *other facility (including a family home, or extended or modified family home) which provides care, during the night, of children whose parents are absent from their home and who need supervision during sleeping hours in order for their parents to be gainfully employed.*

(h) *The term "boarding facility" means a facility (including a boarding home, boarding center, family home, or extended or modified family home) which provides child care for children on a twenty-four hour per day basis (except for periods when the children are attending school) for periods, in the case of any child, not longer than one month.*

(i) *The term "day nursery" means a facility which, during not less than five days each week, provides child care to children of preschool age.*

(j) *The term "nursery school" means a school which accepts for enrollment therein only children between two and six years of age, which is established and operated primarily for educational purposes to meet the developmental needs of the children enrolled therein.*

(k) *The term "kindergarten" means a facility which accepts for enrollment therein only children between four and six years of age, which is established and operated primarily for educational purposes to meet the developmental needs of the children enrolled therein.*

(l) *The term "child development center" means a facility which accepts for enrollment therein only children of preschool age, which is established and operated primarily for educational purposes to meet the developmental needs of the children enrolled therein, and which provides for the children enrolled therein care services, or instruction for not less than five days each week.*

(m) *The term "play group facility" means a facility which accepts as members thereof children of preschool age, which provides care or services to the members thereof for not more than three hours in any*

day, and which is established and operated primarily for recreational purposes.

(n) The term "preschool child care center" means a facility which accepts for enrollment therein children of preschool age, and which provides child care to children enrolled therein on a full-day basis for at least five days each week.

(o) The term "school age child care center" means a facility which accepts for enrollment therein only children of school age, and which provides child care for the children enrolled therein during the portion of the day when they are not attending school for at least five days each week.

(p) The term "summer day care program" means a facility which provides child care for children during summer vacation periods, and which is established and operated primarily for recreational purposes; but such term does not include any program which is operated by any public agency if participation in such program is without charge and is generally available to residents of any political subdivision.

(q) The term "family day care home" means a family home in which child care is provided, during the day, for not more than eight children (including any children under age fourteen who are members of the family living in such home or who reside in such home on a full-time basis).

(r) The term "group day care home" means an extended or modified family residence which offers, during all or part of the day, child care for not less than seven children (not including any child or children who are members of the family, if any, offering such services).

(s) The term "family school age day care home" means a family home which offers child care for not more than eight children, all of school age, during portions of the day when such children are not attending school.

(t) The term "group school age day care home" means an extended or modified family residence which offers family-like child care for not less than seven children (not counting any child or children who are members of the family, if any, offering such services) during portions of the day when such children are not attending school.

(u) The term "temporary child care home" means a family home which offers child care, on a temporary basis, for not more than eight children (including any children under age fourteen who are members of the family, if any, offering such care).

(v) The term "temporary child care center" means a facility (other than a family home) which offers child care, on a temporary basis, to not less than seven children.

(w) The term "night care home" means a family home which offers child care, during the night, for not more than eight children (including any children under age fourteen who are members of the family offering such care).

(x) The term "boarding home" means a family home which provides child care (including room and board) to not more than six children (including any children under age fourteen who are members of the family offering such care).

(y) The term "boarding center" means a summer camp or other facility (other than a family home) which offers child care (including room and board) to not less than seven children.

(z) *The term "facility", as used in connection with the terms "child care", "home child care", "temporary child care", "night care", or "boarding care", shall refer only to buildings and grounds (or portions thereof) actually used (whether exclusively or in part) for the provision of child care services.*

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SOCIAL SECURITY AMENDMENTS OF 1967

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Incentives for Economy While Maintaining or Improving Quality in the Provision of Health Services

Sec. 402. [(a) The Secretary of Health, Education, and Welfare is authorized to develop and engage in experiments under which physicians who would otherwise be entitled to receive payment on the basis of reasonable charge, and organizations and institutions which would otherwise be entitled to reimbursement or payment on the basis of reasonable cost, for services provided—

(1) under title XVIII of the Social Security Act,

(2) under a State plan approved under title XIX of such Act, or

(3) under a plan developed under title V of such Act, and which are selected by the Secretary in accordance with regulations established by the Secretary, would be reimbursed or paid in any manner mutually agreed upon by the Secretary and the physician, organization, or institution. The method of payment (in the case of physicians) or reimbursement (in the case of an organization or institution) which may be applied in such experiments shall be such as the Secretary may select and may be based on charges or costs adjusted by incentive factors and may include specific incentive payments or reductions of payments for the performance of specific actions but in any case shall be such as he determines may, through experiment, be demonstrated to have the effect of increasing the efficiency and economy of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services.]

(a) (1) *The Secretary of Health, Education, and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:*

(A) *to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222 (a) of the Social Security Amendments of 1972) for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;*

(B) to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing—

- (i) comprehensive health care services,
- (ii) mental health care services (as defined by section 401 (c) of the Mental Retardation Facilities and Community Health Centers Construction Act of 1963),
- (iii) ambulatory health care services (including surgical services provided on an outpatient basis), or
- (iv) institutional services which may substitute, at lower cost, for hospital care;

(C) to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by the Social Security Act, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;

(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge for the teaching activities and patient care which residents, interns, and supervising physicians render in connection with a graduate medical education program in a patient facility would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care;

(E) to determine whether coverage of intermediate care facility services and homemaker services would provide suitable alternatives to posthospital benefits presently provided under title XVIII of the Social Security Act; such experiment and demonstration projects may include:

(i) counting each day of care in an intermediate care facility as one day of care in a skilled nursing facility, if such care was for a condition for which the individual was hospitalized.

(ii) covering the services of homemakers for a maximum of 21 days, if institutional services are not medically appropriate,

(iii) determining whether such coverage would reduce long-range costs by reducing the lengths of stay in hospitals and skilled nursing facilities, and

(iv) establishing alternative eligibility requirements and determining the probable cost of applying each alternative, if the project suggests that such extension of coverage would be desirable;

(F) to determine whether, and if so which type of, fixed price or performance incentive contract would have the effect of inducing to the greatest degree effective, efficient, and economical performance of agencies and organizations making payment

under agreements or contracts with the Secretary for health care and services under health programs established by the Social Security Act; and

(G) to determine under what circumstances payment for services would be appropriate and the most appropriate, equitable, and noninflationary methods and amounts of reimbursement under health care programs established by the Social Security Act for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and—

(i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed; and

(ii) for which such physician assumes full legal and ethical responsibility as to the necessity, propriety, and quality thereof.

For purposes of this subsection, "health programs established by the Social Security Act" means the program established by title XVIII of such Act, a program established by a plan of a State approved under title XIX of such Act, and a program established by a plan of a State approved under title V of such Act.

(2) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under paragraph (1) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund established by section 1841 of the Social Security Act) and from funds appropriated under titles V and XIX of such Act. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such titles V and XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(b) In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of titles XVIII, XIX, and V of the Social Security Act insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge [;], or in reimbursement or payment only for such services or items as may be specified in the experiment; and costs incurred in such experiment or demonstration project in excess of the costs which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (which such excess being borne by the Secretary). No experiment or demonstration project shall be engaged in or developed under subsection (a) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experi-

ment *or demonstration project* as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment *or demonstration project*, and its relationship to other similar experiments *and projects* already completed or in process.

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INTERNAL REVENUE CODE OF 1954

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INTERNAL REVENUE TITLE

- SUBTITLE A. Income taxes.
- SUBTITLE B. Estate and gift taxes.
- SUBTITLE C. Employment taxes.
- SUBTITLE D. Miscellaneous excise taxes.
- SUBTITLE E. Alcohol, tobacco, and certain other excise taxes.
- SUBTITLE F. Procedure and administration.
- SUBTITLE G. The Joint Committee on Internal Revenue Taxation.
- SUBTITLE H. Financing of Presidential Election Campaigns.
- SUBTITLE I. *Work Bonus Program.*

Subtitle A—Income Taxes

- CHAPTER 1. Normal taxes and surtaxes.
- CHAPTER 2. Tax on self-employment income.
- CHAPTER 3. Withholding of tax on nonresident aliens and foreign corporations and tax-free covenant bonds.
- CHAPTER 4. Rules applicable to recovery of excessive profits on government contracts.
- CHAPTER 5. Tax on transfers to avoid income tax.
- CHAPTER 6. Consolidated returns.

CHAPTER 1—NORMAL TAXES AND SURTAXES

- SUBCHAPTER A. Determination of tax liability.
- SUBCHAPTER B. Computation of taxable income.
- SUBCHAPTER C. Corporate distributions and adjustments.
- SUBCHAPTER D. Deferred compensation, etc.
- SUBCHAPTER E. Accounting periods and methods of accounting.
- SUBCHAPTER F. Exempt organizations.
- SUBCHAPTER G. Corporations used to avoid income tax on shareholders.
- SUBCHAPTER H. Banking institutions.
- SUBCHAPTER I. Natural resources.
- SUBCHAPTER J. Estates, trusts, beneficiaries, and decedents.
- SUBCHAPTER K. Partners and partnerships.
- SUBCHAPTER L. Insurance companies.
- SUBCHAPTER M. Regulated investment companies.
- SUBCHAPTER N. Tax based on income from sources within or without the United States.
- SUBCHAPTER O. Gain or loss on disposition of property.
- SUBCHAPTER P. Capital gains and losses.
- SUBCHAPTER Q. Readjustment of tax between years and special limitations.
- SUBCHAPTER R. Election of certain partnerships and proprietorships as to taxable status.
- SUBCHAPTER S. Election of certain small business corporations as to taxable status.
- SUBCHAPTER T. Cooperatives and their patrons.

Subchapter A—Determination of Tax Liability

- Part I. Tax on individuals.
- Part II. Tax on corporations.
- Part III. Changes in rates during a taxable year.
- Part IV. Credits against tax.
- Part V. Tax surcharge.
- Part VI. Minimum tax for tax preferences.

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PART IV—CREDITS AGAINST TAX

- Subpart A. Credits allowable.
- Subpart B. Rules for computing credit for investment in certain depreciable property.
- Subpart C. Rules for computing credit for expenses of **[work incentive]** *guaranteed employment* programs.

Subpart A—Credits Allowable

- Sec. 31. Tax withheld on wages.
- Sec. 32. Tax withheld at source on nonresident aliens and foreign corporations and on tax-free covenant bonds.
- Sec. 33. Taxes of foreign countries and possessions of the United States.
- Sec. 35. Partially tax-exempt interest received by individuals.
- Sec. 36. Credits not allowed to individuals paying optional tax or taking standard deduction.
- Sec. 37. Retirement income.
- Sec. 38. Investment in certain depreciable property.
- Sec. 39. Certain uses of gasoline, special fuels, and lubricating oil.
- Sec. 40. Expenses of **[work incentive]** *guaranteed employment* programs.
- Sec. 41. Contributions to candidates for public office.
- Sec. 42. *Work bonus*.
- Sec. **[42]** 43. Overpayments of tax.

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SEC. 31. TAX WITHHELD ON WAGES.

(a) WAGE WITHHOLDING FOR INCOME TAX PURPOSES.—

(1) **IN GENERAL.**—The amount withheld under section 3402 as tax on the wages of any individual shall be allowed to the recipient of the income as a credit against the tax imposed by this subtitle.

(2) **YEAR OF CREDIT.**—The amount so withheld during any calendar year shall be allowed as a credit for the taxable year beginning in such calendar year. If more than one taxable year begins in a calendar year, such amount shall be allowed as a credit for the last taxable year so beginning.

(b) CREDIT FOR SPECIAL REFUNDS OF SOCIAL SECURITY TAX.—

(1) **IN GENERAL.**—The Secretary or his delegate may prescribe regulations providing for the crediting against the tax imposed by this subtitle of the amount determined by the taxpayer or the Secretary (or his delegate) to be allowable under section 6413(c) or (e) as a special refund of tax imposed on wages. The amount allowed as a credit under such regulations shall, for purposes of this subtitle, be considered an amount withheld at source as tax under section 3402.

(2) **YEAR OF CREDIT.**—Any amount to which paragraph (1) applies shall be allowed as a credit for the taxable year beginning in the calendar year during which the wages were received. If more

than one taxable year begins in the calendar year, such amount shall be allowed as a credit for the last taxable year so beginning.

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SEC. 37. RETIREMENT INCOME.

[(a) GENERAL RULE.—In the case of an individual who has received earned income before the beginning of the taxable year, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 17 percent, in the case of a taxable year beginning in 1964, or 15 percent, in the case of a taxable year beginning after December 31, 1964, of the amount received by such individual as retirement income (as defined in subsection (c) and as limited by subsection (d)); but this credit shall not exceed such tax reduced by the credits allowable under section 32(2) (relating to tax withheld at source on tax-free covenant bonds), section 33 (relating to foreign tax credit), and section 35 (relating to partially tax-exempt interest).

[(b) INDIVIDUAL WHO HAS RECEIVED EARNED INCOME.—For purposes of subsection (a), an individual shall be considered to have received earned income if he has received, in each of any 10 calendar years before the taxable year, earned income (as defined in subsection (g)) in excess of \$600. A widow or widower whose spouse had received such earned income shall be considered to have received earned income.

[(c) RETIREMENT INCOME.—For purposes of subsection (a), the term “retirement income” means—

[(1) in the case of an individual who has attained the age of 65 before the close of the taxable year, income from—

[(A) pensions and annuities (including, in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1), distributions by a trust described in section 401(a) which is exempt from tax under section 501(a)),

[(B) interest,

[(C) rents,

[(D) dividends, and

[(E) bonds described in section 405(b)(1) which are received under a qualified bond purchase plan described in section 405(a) or in a distribution from a trust described in section 401(a) which is exempt from tax under section 501(a), or

[(2) in the case of an individual who has not attained the age of 65 before the close of the taxable year, income from pensions and annuities under a public retirement system (as defined in subsection (f)),

to the extent included in gross income without reference to this section, but only to the extent such income does not represent compensation for personal services rendered during the taxable year.

[(d) LIMITATION ON RETIREMENT INCOME.—For purposes of subsection (a), the amount of retirement income shall not exceed \$1,524 less—

[(1) in the case of any individual, any amount received by the individual as a pension or annuity—

[(A) under title II of the Social Security Act,

[(B) under the Railroad Retirement Acts of 1935 or 1937, or

[(C) otherwise excluded from gross income, and

(2) in the case of any individual who has not attained age 72 before the close of the taxable year—

[(A) if such individual has not attained age 62 before the close of the taxable year, any amount of earned income (as defined in subsection (g)) in excess of \$900 received by such individual in the taxable year, or

(B) if such individual has attained age 62 before the close of the taxable year, the sum of (i) one-half the amount of earned income received by such individual in the taxable year in excess of \$1,200 but not in excess of \$1,700, and (ii) the amount of earned income so received in excess of \$1,700.

[(e) **RULE FOR APPLICATION OF SUBSECTION (d)(1).**—Subsection (d)(1) shall not apply to any amount excluded from gross income under section 72 (relating to annuities), 101 (relating to life insurance proceeds), 104 (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 employee annuities).

[(f) **PUBLIC RETIREMENT SYSTEM DEFINED.**—For purposes of subsection (c)(2), the term “public retirement system” means a pension, annuity, retirement, or similar fund or system established by the United States, a State, a Territory, a possession of the United States, any political subdivision of any of the foregoing, or the District of Columbia.

[(g) **EARNED INCOME DEFINED.**—For purposes of subsections (b) and (d) (2), the term “earned income” has the meaning assigned to such term in section 911(b), except that such term does not include any amount received as a pension or annuity.

[(h) **NONRESIDENT ALIEN INELIGIBLE FOR CREDIT.**—No credit shall be allowed under subsection (a) to any nonresident alien.

[(i) **SPECIAL RULES FOR CERTAIN MARRIED COUPLES.**—

[(1) **ELECTION.**—A husband and wife who make a joint return for the taxable year and both of whom have attained the age of 65 before the close of the taxable year may elect (at such time and in such manner as the Secretary or his delegate by regulations prescribes) to determine the amount of the credit allowed by subsection (a) by applying the provisions of paragraph (2).

[(2) **SPECIAL RULES.**—If an election is made under paragraph (1) for the taxable year, for purposes of subsection (a)—

[(A) if either spouse is an individual who has received earned income within the meaning of subsection (b), the other spouse shall be considered to be an individual who has received earned income within the meaning of such subsection; and

[(B) subsection (d) shall be considered as providing that the amount of the combined retirement income of both spouses shall not exceed \$2,286, less the sum of the amounts specified in paragraphs (1) and (2) of subsection (d) for each spouse.

[(j) **CROSS REFERENCE.**—

[For disallowance of credit where tax is computed by Secretary or his delegate, see section 6014(a).]

(a) **GENERAL RULES.**—

(1) **JOINT RETURNS.**—*In the case of a joint return—*

(A) *if either spouse has attained the age of 65 before the close of the taxable year, or*

(B) if neither spouse has attained the age of 65 before the close of the taxable year but one or both spouses have public retirement system pension income for the taxable year.

there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 15 percent of the retirement income (as limited by subsection (b)) received by the husband and wife during the taxable year.

(2) OTHER RETURNS.—In the case of a return by an unmarried individual and of a separate return by a married individual—

(A) if the individual has attained the age of 65 before the close of the taxable year, or

(B) if the individual has not attained the age of 65 before the close of the taxable year but has public retirement system pension income for the taxable year,

there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 15 percent of the retirement income (as limited by subsection (b)) received by the individual during the taxable year.

(b) LIMITATION OF RETIREMENT INCOME.—

(1) IN GENERAL.—The amount of retirement income which may be taken into account for purposes of subsection (a) shall not exceed the following amounts (reduced as provided in paragraph (2)):

(A) \$2,500, in the case of an unmarried individual,

(B) \$2,500, in the case of a joint return where only one spouse is an eligible individual,

(C) \$3,750, in the case of a joint return where both spouses are eligible individuals, or

(D) \$1,875, in the case of separate return by a married individual.

(2) REDUCTION.—Except as provided in paragraphs (3) and (4), the reduction under this paragraph in the case of any individual is—

(A) any amount received by such individual as a pension or annuity—

(i) under title II of the Social Security Act,

(ii) under the Railroad Retirement Act of 1935 or 1937, or

(iii) otherwise excluded from gross income, plus

(B) in the case of any individual who has not attained age 72 before the close of the taxable year—

(i) except as provided in clause (ii), one-half the amount of earned income received by such individual in the taxable year in excess of \$2,000, or

(ii) if such individual has not attained age 62 before the close of the taxable year, and if such individual (or his spouse under age 62) is an eligible individual as defined in subsection (d)(4)(B), any amount of earned income in excess of \$1,000 received by such individual in the taxable year.

(3) SPECIAL RULES FOR DETERMINING THE REDUCTION PROVIDED IN PARAGRAPH (2).—

(A) JOINT RETURNS.—In the case of a joint return, the reduction under paragraph (2) shall be the aggregate of the amounts resulting from applying paragraph (2) separately to each spouse.

(B) SEPARATE RETURNS OF MARRIED INDIVIDUALS.—In the case of a separate return of a married individual, paragraph (2)(B)(i) shall be applied by substituting "\$1,000" for "\$2,000", and paragraph (2)(B)(ii) shall be applied by substituting "\$500" for "\$1,000".

(C) **NO REDUCTION FOR CERTAIN AMOUNTS EXCLUDED FROM GROSS INCOME.**—No reduction shall be made under paragraph (2)(A) for any amount excluded from gross income under section 72 (relating to annuities), 101 (relating to life insurance proceeds), 104 (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 employee annuities).

(4) **SPECIAL RULE FOR CERTAIN INDIVIDUALS RECEIVING PUBLIC RETIREMENT SYSTEM PENSION INCOME.**—In the case of a joint return where one spouse is an eligible individual as defined in subsection (d)(4)(A) and the other spouse is an eligible individual as defined in subsection (d)(4)(B), there shall be an additional reduction under paragraph (2) in an amount equal to the excess (if any) of \$1,250 over the amount of the public retirement system pension income of the spouse who is an eligible individual as defined in subsection (d)(4)(B).

(c) **RETIREMENT INCOME.**—For purposes of this section—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the term “retirement income” means income from—

(A) pensions and annuities (including public retirement system pension income and including, in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1), distributions by a trust described in section 401(a) which is exempt from tax under section 501(a)),

(B) interest,

(C) rents,

(D) dividends, and

(E) bonds described in section 405(b)(1) which are received under a qualified bond purchase plan described in section 405(a) or in a distribution from a trust described in section 401(a) which is exempt from tax under section 501(a),

to the extent included in gross income without reference to this section, but only to the extent such income does not represent compensation for personal services rendered during the taxable year.

(2) **CERTAIN INDIVIDUALS UNDER AGE 65.**—In the case of—

(A) a return by an unmarried individual who has not attained the age of 65 before the close of the taxable year,

(B) a separate return by a married individual who has not attained the age of 65 before the close of the taxable year, and

(C) a joint return if neither spouse has attained the age of 65 before the close of the taxable year,

the term “retirement income” means only public retirement system pension income, and only so much of such income received by an individual during the taxable year as does not exceed \$2,500.

(d) **OTHER DEFINITIONS AND SPECIAL RULES.**—For purposes of this section.—

(1) **PUBLIC RETIREMENT SYSTEM PENSION INCOME.**—The term “public retirement system pension income” means income from pensions and annuities under a public retirement system for personal services performed by the taxpayer or his spouse, to the extent included in gross income without reference to this section, but only to the extent such income does not represent compensation for personal services rendered during the taxable year. For purposes of this paragraph, the term

“public retirement system” means a pension, annuity, retirement, or similar fund or system established by the United States, a State, a possession of the United States, any political subdivision of any of the foregoing, or the District of Columbia.

(2) *EARNED INCOME.*—The term “earned income” has the meaning assigned to such term in section 911(b) except that such term does not include any amount received as a pension or annuity.

(3) *COMMUNITY PROPERTY LAWS DISREGARDED.*—The determination of whether—

(A) earned income, or

(B) income from pensions and annuities for personal services (including public retirement system pension income and distributions to which subsection (c)(1)(A) applies),
is the income of a husband or wife shall be made without regard to community property laws.

(4) *ELIGIBLE INDIVIDUAL.*—The term “eligible individual” means an individual who—

(A) has attained the age of 65 before the close of the taxable year, or

(B) has not attained such age but has public retirement system pension income for the taxable year.

(5) *MARITAL STATUS.*—Marital status shall be determined under section 153.

(6) *JOINT RETURN.*—The term “joint return” means the joint return of a husband and wife made under section 6013.

(e) *NONRESIDENT ALIEN INELIGIBLE FOR CREDIT.*—No credit shall be allowed under this section to any nonresident alien.

* * * * *

SEC. 40. EXPENSES OF [WORK INCENTIVE] GUARANTEED EMPLOYMENT PROGRAMS.

(a) *GENERAL RULE.*—There shall be allowed, as a credit against the tax imposed by this chapter, the amount determined under subpart C of this part.

(b) *REGULATIONS.*—The Secretary or his delegate shall prescribe such regulations as may be necessary to carry out the purposes of this section and subpart C.

* * * * *

SEC. 42. WORK BONUS.

There shall be allowed to a taxpayer who is an eligible individual (as defined in section 10005) and who makes an election under section 10001 (d) for the taxable year, as a credit against the tax imposed by this chapter an amount equal to any amount to which he is entitled under chapter 97 for that year unless he has applied to receive that amount as a payment under that chapter. The Secretary or his delegate shall prescribe such regulations as may be necessary to carry out the provisions of this section.

SEC. [42.] 43. OVERPAYMENTS OF TAX.

For credit against the tax imposed by this subtitle for overpayments of tax, see section 6401.

* * * * *

**Subpart C—Rules for Computing Credit for Expenses of
【Work Incentive】 Guaranteed Employment Programs**

Sec. 50A. Amount of credit.

Sec. 50B. Definitions; special rules.

SEC. 50A. AMOUNT OF CREDIT.

(a) **DETERMINATION OF AMOUNT.**—

(1) **GENERAL RULE.**—The amount of the credit allowed by section 40 for the taxable year shall be equal to 20 percent of the 【work incentive】 *guaranteed employment* program expenses (as defined in section 50B(a)).

(2) **LIMITATION BASED ON AMOUNT OF TAX.**—Notwithstanding paragraph (1), the credit allowed by section 40 for the taxable year shall not exceed—

(A) so much of the liability for tax for the taxable year as does not exceed \$25,000, plus

(B) 50 percent of so much of the liability for tax for the taxable year as exceeds \$25,000.

(3) **LIABILITY FOR TAX.**—For purposes for paragraph (2), the liability for tax for the taxable year shall be the tax imposed by this chapter for such year, reduced by the sum of the credits allowable under—

(A) section 33 (relating to foreign tax credit),

(B) section 35 (relating to partially tax exempt interest),

(C) section 37 (relating to retirement income),

(D) section 38 (relating to investment in certain depreciable property), and

(E) section 41 (relating to contributions to candidates for public office).

For purposes of this paragraph, any tax imposed for the taxable year by section 56 (relating to minimum tax for tax preferences), section 531 (relating to accumulated earnings tax), section 541 (relating to personal holding company tax), or section 1378 (relating to tax on certain capital gains of subchapter S corporations), and any additional tax imposed for the taxable year by section 1351(d)(1) (relating to recoveries of foreign expropriation losses), shall not be considered tax imposed by this chapter for such year.

(4) **MARRIED INDIVIDUALS.**—In the case of a husband or wife who files a separate return, the amount specified under subparagraphs (A) and (B) of paragraph (2) shall be \$12,500 in lieu of \$25,000. This paragraph shall not apply if the spouse of the taxpayer has no 【work incentive】 *guaranteed employment* program expenses for, and no unused credit carryback or carryover to, the taxable year of such spouse which ends within or with the taxpayer's taxable year.

(5) **CONTROLLED GROUPS.**—In the case of a contro group, the \$25,000 amount specified under paragraph (2) shall be reduced for each component member of such group by apportioning \$25,000 among the component members of such group in such manner as the Secretary or his delegate shall by regulations prescribe. For purposes of the preceding sentence, the term "controlled group" has the meaning assigned to such term by section 1563(a).

(b) **CARRYBACK AND CARRYOVER OF UNUSED CREDIT.**—

(1) **ALLOWANCE OF CREDIT.**—If the amount of the credit determined under subsection (a)(1) for any taxable year exceeds the

limitation provided by subsection (a)(2) for such taxable year (hereinafter in this subsection referred to as "unused credit year"), such excess shall be—

(A) a **[work incentive]** *guaranteed employment* program credit carryback to each of the 3 taxable years preceding the unused credit year, and

(B) a **[work incentive]** *guaranteed employment* program credit carryover to each of the 7 taxable years following the unused credit year

and shall be added to the amount allowable as a credit by section 40 for such years, except that such excess may be a carryback only to a taxable year beginning after December 31, 1971. The entire amount of the unused credit for an unused credit year shall be carried to the earliest of the 10 taxable years to which (by reason of subparagraphs (A) and (B)) such credit may be carried, and then to each of the other 9 taxable years to the extent that, because of the limitation contained in paragraph (2), such unused credit may not be added for a prior taxable year to which such unused credit may be carried.

(2) **LIMITATION.**—The amount of the unused credit which may be added under paragraph (1) for any preceding or succeeding taxable year shall not exceed the amount by which the limitation provided by subsection (a)(2) for such taxable year exceeds the sum of—

(A) the credit allowable under subsection (a)(1) for such taxable year, and

(B) the amounts which, by reason of this subsection, are added to the amount allowable for such taxable year and attributable to taxable years preceding the unused credit year.

(c) **EARLY TERMINATION OF EMPLOYMENT BY EMPLOYER, ETC.**—

(1) **GENERAL RULE.**—Under regulations prescribed by the Secretary or his delegate—

(A) **[WORK INCENTIVE] GUARANTEED EMPLOYMENT PROGRAM EXPENSES.**—If the employment of any employee with respect to whom **[work incentive]** *guaranteed employment* program expenses are taken into account under subsection (a) is terminated by the taxpayer at any time during the first 12 months of such employment (whether or not consecutive) or before the close of the 12th calendar month after the calendar month in which such employee completes 12 months of employment with the taxpayer, the tax under this chapter for the taxable year in which such employment is terminated shall be increased by an amount (determined under such regulations) equal to the credits allowed under section 40 for such taxable year and all prior taxable years attributable to **[work incentive]** *guaranteed employment* program expenses paid or incurred with respect to such employee.

(B) **CARRYBACKS AND CARRYOVERS ADJUSTED.**—In the case of any termination of employment to which subparagraph (A) applies, the carrybacks and carryovers under subsection (b) shall be properly adjusted.

(2) **SUBSECTION NOT TO APPLY IN CERTAIN CASES.**—

(A) **IN GENERAL.**—Paragraph (1) shall not apply to—

(i) a termination of employment of an employee who voluntarily leaves the employment of the taxpayer.

(ii) a termination of employment of an individual who, before the close of the period referred to in paragraph (1)(A), becomes disabled to perform the services of such employment, unless such disability is removed before the close of such period and the taxpayer fails to offer reemployment to such individual, or

(iii) a termination of employment of an individual, if it is determined under the applicable State unemployment compensation law that the termination was due to the misconduct of such individual.

(B) CHANGE IN FORM OF BUSINESS, ETC.—For purposes of paragraph (1), the employment relationship between the taxpayer and an employee shall not be treated as terminated—

(i) by a transaction to which section 381(a) applies, if the employee continues to be employed by the acquiring corporation, or

(ii) by reason of a mere change in the form of conducting the trade or business of the taxpayer, if the employee continues to be employed in such trade or business and the taxpayer retains a substantial interest in such trade or business.

(3) SPECIAL RULE.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit allowable under subpart A.

(d) FAILURE TO PAY COMPARABLE WAGES.—

(1) GENERAL RULE.—Under regulations prescribed by the Secretary or his delegate, if during the period described in subsection (c)(1)(A), the taxpayer pays wages (as defined in section 50B(b)) to an employee with respect to whom **[work incentive] guaranteed employment** program expenses are taken into account under subsection (a) which are less than the wages paid to other employees who perform comparable services, the tax under this chapter for the taxable year in which such wages are so paid shall be increased by an amount (determined under such regulations) equal to the credits allowed under section 40 for such taxable year and all prior taxable years attributable to **[work incentive] guaranteed employment** program expenses paid or incurred with respect to such employee, and the carrybacks and carryovers under subsection (b) shall be properly adjusted.

(2) SPECIAL RULE.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit allowable under subpart A.

SEC. 50B. DEFINITIONS; SPECIAL RULES.

(a) **[WORK INCENTIVE] GUARANTEED EMPLOYMENT PROGRAM EXPENSES.**—For purposes of this subpart, the term “**[work incentive] guaranteed employment** program expenses” means the wages paid or incurred by the taxpayer for services rendered during the first 12 months of employment (whether or not consecutive) of employees who are certified by the Secretary of Labor as—

[(1) having been placed in employment under a work incentive program established under section 432(b)(1) of the Social Security Act, and]

(1) having participated, immediately prior to employment by the taxpayer, for at least one month in the guaranteed employment program

administered by the Work Administration under title XX of the Social Security Act, and

(2) not having displaced any individual from employment.

(b) **WAGES.**—For purposes of subsection (a), the term “wages” means only cash remuneration (including amounts deducted and withheld).

(c) **LIMITATIONS.**—

【(1) **TRADE OR BUSINESS EXPENSES.**—No item shall be taken into account under subsection (a) unless such item is incurred in a trade or business of the taxpayer.】

(1) **AMOUNT OF WAGES PER EMPLOYEE.**—The amount of wages paid or incurred during the taxable year with respect to any employee certified under subsection (a)—

(A) who is a nonbusiness employee, or

(B) whose employment by the taxpayer begins after December 31, 1973,

which may be taken into account under that subsection shall not include so much of the wages paid or incurred during the taxable year as exceeds an annual rate of \$4,000.

(2) **TOTAL AMOUNT OF WAGES PER YEAR.**—

(A) **IN GENERAL.**—The total amount of wages paid or incurred during the taxable year with respect to all employees certified under subsection (a)—

(i) who are nonbusiness employees, or

(ii) whose employment by the taxpayer begins after December 31, 1973,

which may be taken into account under this subsection shall not exceed 15 percent of so much of the aggregate wages paid or incurred during the taxable year with respect to all employees of the taxpayer as does not exceed, in the case of each employee, the average rate of the wages paid or incurred during the taxable year with respect to employees certified under subsection (a) (to the extent such wages are taken into account under paragraph (1)).

(B) **WAGES OF ONE EMPLOYEE.**—The total amount of wages which may be taken into account under subparagraph (A) shall not be less than the amount of wages which are taken into account under paragraph (1) with respect to one employee. In the case a husband and wife who file separate returns, the preceding sentence shall apply, with respect to nonbusiness employees, only to the spouse designated by them in such manner as the Secretary or his delegate prescribes by regulations

(C) **BUSINESS AND NONBUSINESS EMPLOYEES.**—Subparagraphs (A) and (B) shall apply separately with respect to nonbusiness employees of the taxpayer.

【(2)】 (3) **REIMBURSED EXPENSES.**—No item shall be taken into account under subsection (a) to the extent that the taxpayer is reimbursed for such item.

【(3)】 (4) **GEOGRAPHICAL LIMITATION.**—No item shall be taken into account under subsection (a) with respect to any expense paid or incurred by the taxpayer with respect to employment outside the United States.

【(4)】 (5) **MAXIMUM PERIOD OF TRAINING OR INSTRUCTION.**—No item with respect to any employee shall be taken into account

under subsection (a) after the end of the 24-month period beginning with the date of initial employment of such employee by the taxpayer.

[(5)] (6) INELIGIBLE INDIVIDUALS.—No item shall be taken into account under subsection (a) with respect to an individual who—

(A) bears any of the relationships described in paragraphs (1) through (8) of section 152(a) to the taxpayer, or, if the taxpayer is a corporation, to an individual who owns, directly or indirectly, more than 50 percent in value of the outstanding stock of the corporation (determined with the application of section 267(c)),

(B) if the taxpayer is an estate or trust, is a grantor, beneficiary, or fiduciary of the estate or trust, or is an individual who bears any of the relationships described in paragraphs (1) through (8) of section 152(a) to a grantor, beneficiary, or fiduciary of the estate or trust, or

(C) is a dependent (described in section 152(a)(9)) of the taxpayer, or, if the taxpayer is a corporation, of an individual described in subparagraph (A), or, if the taxpayer is an estate or trust, of a grantor, beneficiary, or fiduciary of the estate or trust.

(d) **SUBCHAPTER S CORPORATIONS.**—In case of an electing small business corporation (as defined in section 1371)—

(1) the **[work incentive]** *guaranteed employment* program expenses for each taxable year shall be apportioned pro rata among the persons who are shareholders of such corporation on the last day of such taxable year, and

(2) any person to whom any expenses have been apportioned under paragraph (1) shall be treated (for purposes of this subpart) as the taxpayer with respect to such expenses.

(e) **ESTATES AND TRUSTS.**—In the case of an estate or trust—

(1) the **[work incentive]** *guaranteed employment* program expenses for any taxable year shall be apportioned between the estate or trust and the beneficiaries on the basis of the income of the estate or trust allocable to each,

(2) any beneficiary to whom any expenses have been apportioned under paragraph (1) shall be treated (for purposes of this subpart) as the taxpayer with respect to such expenses, and

(3) the \$25,000 amount specified under subparagraphs (A) and (B) of section 50A(a)(2) applicable to such estate or trust shall be reduced to an amount which bears the same ratio to \$25,000 as the amount of the expenses allocated to the trust paragraph (1) bears to the entire amount of such expenses.

(f) **LIMITATIONS WITH RESPECT TO CERTAIN PERSONS.**—In the case of—

(1) an organization to which section 593 applies,

(2) a regulated investment company or a real estate investment trust subject to taxation under subchapter M (section 851 and following), and

(3) a cooperative organization described in section 1381(a), rules similar to the rules provided in section 46(d) shall apply under regulations prescribed by the Secretary or his delegate.

(g) **NONBUSINESS EMPLOYEES.**—

(1) **ELECTION.**—*Subsection (a) shall apply with respect to non-business employees of the taxpayer only if the taxpayer makes an*

election under this subsection. Such election shall be made for any taxable year in such manner and within such time as the Secretary or his delegate prescribes by regulations.

(2) *DENIAL OF DEDUCTION UNDER SECTION 214.—If the taxpayer makes an election under paragraph (1) for a taxable year, no deduction shall be allowable to the taxpayer under section 214 (relating to expenses for household and dependent care services necessary for gainful employment) for such taxable year.*

(5) *NONBUSINESS EMPLOYEE DEFINED.—For purposes of this section, an employee is a nonbusiness employee of the taxpayer if his services are not performed in connection with a trade or business of the taxpayer.*

[(g)] (h) CROSS REFERENCE.—

For application of this subpart to certain acquiring corporations, see section 381(c)(24).

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Subchapter B—Computation of Taxable Income

- Part I. Definition of gross income, adjusted gross income, and taxable income.
- Part II. Items specifically included in gross income.
- Part III. Items specifically excluded from gross income.
- Part IV. Standard deduction for individuals.
- Part V. Deductions for personal exemptions.
- Part VI. Itemized deductions for individuals and corporations.
- Part VII. Additional itemized deductions for individuals.
- Part VIII. Special deductions for corporations.
- Part IX. Items not deductible.
- Part X. Terminal railroad corporations and their shareholders

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PART II—ITEMS SPECIFICALLY INCLUDED IN GROSS INCOME

- Sec. 71. Alimony and separate maintenance payments.
- Sec. 72. Annuities; certain proceeds of endowment and life insurance contracts.
- Sec. 73. Services of child.
- Sec. 74. Prizes and awards.
- Sec. 75. Dealers in tax-exempt securities.
- Sec. 76. Mortgages made or obligations issued by joint-stock land banks.
- Sec. 77. Commodity credit loans.
- Sec. 78. Dividends received from certain foreign corporations by domestic corporations choosing foreign tax credit.
- Sec. 79. Group-term life insurance purchased for employees.
- Sec. 80. Restoration of value of certain securities.
- Sec. 81. Increases in expense account under section 166(g).
- Sec. 82. Reimbursement for expenses of moving.
- Sec. 83. Property transferred in connection with performance of services.

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SEC. 72. ANNUITIES; CERTAIN PROCEEDS OF ENDOWMENT AND LIFE INSURANCE CONTRACTS.

* * * * *

(n) **TREATMENT OF TOTAL DISTRIBUTIONS.—**

(1) **APPLICATION OF SUBSECTION.—**

(A) **GENERAL RULE.—**This subsection shall apply to amounts—

(i) distributed to a distributee, in the case of an employees' trust described in section 401(a) which is exempt from tax under section 501(a), or

(ii) paid to a payee, in the case of an annuity plan described in section 403(a),

if the total distributions or amounts payable to the distributee or payee with respect to an employee (including an individual who is an employee within the meaning of section 401(c)(1)) are paid to the distributee or payee within one taxable year of the distributee or payee, but only to the extent that section 402(a)(2) or 403(a)(2)(A) does not apply to such amounts.

(B) **DISTRIBUTIONS TO WHICH APPLICABLE.—**This subsection shall apply only to distributions or amounts paid—

(i) on account of the employee's death,

(ii) with respect to an individual who is an employee without regard to section 401(c)(1), on account of his separation from the service,

(iii) with respect to an employee within the meaning of section 401(c)(1), after he has attained the age of 59½ years, or

(iv) with respect to an employee within the meaning of section 401(c)(1), after he has become disabled (within the meaning of subsection (m)(7)).

(C) **MINIMUM PERIOD OF SERVICE.—**This subsection shall apply to amounts distributed or paid to an employee from or under a plan only if he has been a participant in the plan for 5 or more taxable years prior to the taxable year in which such amounts are distributed or paid.

(D) **AMOUNTS SUBJECT TO PENALTY.—**This subsection shall not apply to amounts described in clauses (ii) and (iii) of subparagraph (A) of subsection (m)(5) (but, in the case of amounts described in clause (ii) of such subparagraph, only to the extent that subsection (m)(5) applies to such amounts).

(2) **LIMITATION OF TAX.—**In any case to which this subsection applies, the tax attributable to the amounts to which this subsection applies for the taxable year in which such amounts are received shall not exceed whichever of the following is the greater:

(A) 5 times the increase in tax which would result from the inclusion in gross income of the recipient of 20 percent of so much of the amount so received as is includible in gross income, or

(B) 5 times the increase in tax which would result if the taxable income of the recipient for such taxable year equaled 20 percent of the amount of the taxable income of the recipient for such taxable year determined under paragraph (3)(A).

(3) **DETERMINATION OF TAXABLE INCOME.—**Notwithstanding section 63 (relating to definition of taxable income), for purposes only of computing the tax under this chapter attributable to

amounts to which this subsection or subsection (m)(5) applies and which are includible in gross income—

(A) the taxable income of the recipient for the taxable year of receipt shall be treated as being not less than the amount by which (i) the aggregate of such amounts so includible in gross income exceeds (ii) the amount of the deductions allowed for such taxable year under section 151 (relating to deductions for personal exemptions); and

(B) in making ratable inclusion computations under paragraph (5)(B) of subsection (m), the taxable income of the recipient for each taxable year involved in such ratable inclusion shall be treated as being not less than the amount required by such paragraph (5)(B) to be treated as includible in gross income for such taxable year.

In any case in which the preceding sentence results in an increase in taxable income for any taxable year, the resulting increase in the taxes imposed by section 1 or 3 for such taxable year shall not be reduced by any credit under part IV of subchapter A (other than sections [31 and 39] 31, 39, and 42 thereof) which, but for this sentence, would be allowable.

(4) SPECIAL RULE FOR EMPLOYEES WITHOUT REGARD TO SECTION 401(c)(1).—In the case of amounts to which this subsection applies which are distributed or paid with respect to an individual who is an employee without regard to section 401(c)(1), paragraph (2) shall be applied with the following modifications:

(A) “7 times” shall be substituted for “5 times”, and “14½ percent” shall be substituted for “20 percent”.

(B) Any amount which is received during the taxable year by the employee as compensation (other than as deferred compensation within the meaning of section 404) for personal services performed for the employer in respect of whom the amounts distributed or paid are received shall not be taken into account.

(C) No portion of the total distributions or amounts payable (of which the amounts distributed or paid are a part) to which section 402(a)(2) or 403(a)(2)(A) applies shall be taken into account.

Subparagraph (B) shall not apply if the employee has not attained the age of 59½ years, unless he has died or become disabled (within the meaning of subsection (m)(7)).

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

- Sec. 101. Certain death benefits.
- Sec. 102. Gifts and inheritances.
- Sec. 103. Interest on certain governmental obligations.
- Sec. 104. Compensation for injuries or sickness.
- Sec. 105. Amounts received under accident and health plans.
- Sec. 106. Contributions by employer to accident and health plans.
- Sec. 107. Rental value of parsonages.
- Sec. 108. Income from discharge of indebtedness.
- Sec. 109. Improvements by lessee on lessor's property.
- Sec. 110. Income taxes paid by lessee corporation.

- Sec. 111. Recovery of bad debts, prior taxes, and delinquency amounts.
 Sec. 112. Certain combat pay of members of the Armed Forces.
 Sec. 113. Mustering-out payments for members of the Armed Forces.
 Sec. 114. Sports programs conducted for the American National Red Cross.
 Sec. 115. Income of States, municipalities, etc.
 Sec. 116. Partial exclusion of dividends received by individuals.
 Sec. 117. Scholarships and fellowship grants.
 Sec. 118. Contributions to the capital of a corporation.
 Sec. 119. Meals or lodging furnished for the convenience of the employer.
 Sec. 121. Gain from sale or exchange of residence of individual who has attained age 65.
 Sec. 122. Certain reduced uniformed services retirement pay.
 Sec. 123. Amounts received under insurance contracts for certain living expenses.
 Sec. 124. *Work bonus payments.*
 Sec. [124] 125. Cross references to other Acts.

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SEC. 124. WORK BONUS PAYMENTS.

Gross income does not include any amount received as a payment under chapter 97.

SEC. [124.] 125. CROSS REFERENCES TO OTHER ACTS.

(a) For exemption of—

- (1) Adjustments of indebtedness under wage earners' plans, see section 679 of the Bankruptcy Act (52 Stat. 938; 11 U.S.C. 1079);
- (2) Allowances and expenditures to meet losses sustained by persons serving the United States abroad, due to appreciation of foreign currencies, see the Acts of March 6, 1934 (48 Stat. 466; 5 U.S.C. 118c) and April 25, 1938 (52 Stat. 221; 5 U.S.C. 118c-1);
- (3) Amounts credited to the Maritime Administration under section 9 (b) (6) of the Merchant Ship Sales Act of 1946, see section 9 (c) (1) of that Act (60 Stat. 48; 50 U.S.C. App. 1742);
- (4) Benefits under World War Adjusted Compensation Act, see section 308 of that Act, as amended (43 Stat. 125; 44 Stat. 827, § 3; 38 U.S.C. 618);
- (5) Benefits under World War Veterans' Act, 1924, see section 3 of the Act of August 12, 1935 (49 Stat. 609; 38 U.S.C. 454a);
- (6) Dividends and interest derived from certain preferred stock by Reconstruction Finance Corporation, see section 304 of the Act of March 9, 1933, as amended (49 Stat. 1185; 12 U.S.C. 51d);
- (7) Earnings of ship contractors deposited in special reserve funds, see section 607 (h) of the Merchant Marine Act, 1936, as amended (52 Stat. 961, § 28; 46 U.S.C. 1177);
- (8) Income derived from Federal Reserve banks, including capital stock and surplus, see section 7 of the Federal Reserve Act (38 Stat. 258; 12 U.S.C. 531);
- (9) Income derived from Ogdensburg bridge across Saint Lawrence River, see section 4 of the Act of June 14, 1933, as amended (54 Stat. 259, § 2);
- (10) Income derived from Owensboro bridge across Ohio River and nearby ferries, see section 4 of the Act of August 14, 1937 (50 Stat. 643);
- (11) Income derived from Saint Clair River bridge and ferries,

see section 4 of the Act of June 25, 1930, as amended (48 Stat. 140, § 1);

(12) Leave compensation payments under section 6 of Armed Forces Leave Act of 1946, see section 7 of that Act (60 Stat. 967; 37 U.S.C. 36);

(13) Mustering-out payments made to or on account for veterans under the Mustering-Out Payment Act of 1944, see section 5 (a) of that Act (58 Stat. 10; 38 U.S.C. 691e);

(14) Railroad retirement annuities and pensions, see section 12 of the Railroad Retirement Act of 1935, as amended (50 Stat. 316; 45 U.S.C. 2281);

(15) Railroad unemployment benefits, see section 2 (e) of the Railroad Unemployment Insurance Act, as amended (52 Stat. 1097; 53 Stat. 845, § 9; 45 U.S.C. 352);

(16) Special pensions of persons on Army and Navy medal of honor roll, see section 3 of the Act of April 27, 1916 (39 Stat. 54; 38 U.S.C. 393);

(17) Gain derived from the sale or other disposition of Treasury Bills, issued after June 17, 1930, under the Second Liberty Bond Act, as amended, see Act of June 17, 1930 (C. 512, 46 Stat. 775; 31 U.S.C. 754);

(18) Benefits under laws administered by the Veterans' Administration, see section 3101 of title 38, United States Code.

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Subchapter C—Corporate Distributions and Adjustments

Part I. Distributions by corporations.

Part II. Corporate liquidations.

Part III. Corporate organizations and reorganizations.

Part IV. Insolvency reorganizations.

Part V. Carryovers.

Part VI. Treatment of certain corporate interests as stock or indebtedness.

Part VII. Effective date of subchapter C.

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PART V—CARRYOVERS

Sec. 381. Carryovers in certain corporate acquisitions.

Sec. 382. Special limitations on net operating loss carryovers.

Sec. 383. Special limitations on carryovers of unused investment credits, **work incentive** *guaranteed employment* program credits, foreign taxes, and capital losses.

SEC. 381. CARRYOVERS IN CERTAIN CORPORATE ACQUISITIONS.

(a) **GENERAL RULE.**—In the case of the acquisition of assets of a corporation by another corporation—

(1) in a distribution to such other corporation to which section 332 (relating to liquidations of subsidiaries) applies, except in a case in which the basis of the assets distributed is determined under section 334(b)(2); or

(2) in a transfer to which section 361 (relating to nonrecognition of gain or loss to corporations) applies, but only if the transfer is in connection with a reorganization described in subparagraph (A), (C), (D) (but only if the requirements of subparagraphs (A) and (B) of section 354(b)(1) are met), or (F) of section 368(a)(1), the acquiring corporation shall succeed to and take into account, as of the close of the day of distribution or transfer, the items described in subsection (c) of the distributor or transferor corporation, subject to the conditions and limitations specified in subsections (b) and (c).

(b) **OPERATING RULES.**—Except in the case of an acquisition in connection with a reorganization described in subparagraph (F) of section 368(a)(1)—

(1) The taxable year of the distributor or transferor corporation shall end on the date of distribution or transfer.

(2) For purposes of this section, the date of distribution or transfer shall be the day on which the distribution or transfer is completed; except that, under regulations prescribed by the Secretary or his delegate, the date when substantially all of the property has been distributed or transferred may be used if the distributor or transferor corporation ceases all operations, other than liquidating activities, after such date.

(3) The corporation acquiring property in a distribution or transfer described in subsection (a) shall not be entitled to carry back a net operating loss or a net capital loss for a taxable year ending after the date of distribution or transfer to a taxable year of the distributor or transferor corporation.

(c) **ITEMS OF THE DISTRIBUTOR OR TRANSFEROR CORPORATION.**—The items referred to in subsection (a) are:

(1) **NET OPERATING LOSS CARRYOVERS.**—The net operating loss carryovers determined under section 172, subject to the following conditions and limitations:

(A) The taxable year of the acquiring corporation to which the net operating loss carryovers of the distributor or transferor corporation are first carried shall be the first taxable year ending after the date of distribution or transfer.

(B) In determining the net operating loss deduction, the portion of such deduction attributable to the net operating loss carryovers of the distributor or transferor corporation to the first taxable year of the acquiring corporation ending after the date of distribution or transfer shall be limited to an amount which bears the same ratio to the taxable income (determined without regard to a net operating loss deduction) of the acquiring corporation in such taxable year as the number of days in the taxable year after the date of distribution or transfer bears to the total number of days in the taxable year.

(C) For the purpose of determining the amount of the net operating loss carryovers under section 172 (b) (2), a net operating loss for a taxable year (hereinafter in this subparagraph referred to as the "loss year") of a distributor or transferor corporation which ends on or before the end of a loss year of the acquiring corporation shall be considered to be a net operating loss for a year prior to such loss year of the acquiring corporation. For the same purpose, the taxable income for a "prior taxable year" (as

the term is used in section 172 (b) (2)) shall be computed as provided in such section; except that, if the date of distribution or transfer is on a day other than the last day of a taxable year of the acquiring corporation—

(i) such taxable year shall (for the purpose of this subparagraph only) be considered to be 2 taxable years (hereinafter in this subparagraph referred to as the “pre-acquisition part year” and the “post-acquisition part year”);

(ii) the pre-acquisition part year shall begin on the same day as such taxable year begins and shall end on the date of distribution or transfer;

(iii) the post-acquisition part year shall begin on the day following the date of distribution or transfer and shall end on the same day as the end of such taxable year;

(iv) the taxable income for such taxable year (computed with the modifications specified in section 172 (b) (2) (A) but without a net operating loss deduction) shall be divided between the pre-acquisition part year and the post-acquisition part year in proportion to the number of days in each;

(v) the net operating loss deduction for the pre-acquisition part year shall be determined as provided in section 172 (b) (2) (B), but without regard to a net operating loss year of the distributor or transferor corporation; and

(vi) the net operating loss deduction for the post-acquisition part year shall be determined as provided in section 172 (b) (2) (B).

(2) EARNINGS AND PROFITS.—In the case of a distribution or transfer described in subsection (a)—

(A) the earnings and profits or deficit in earnings and profits, as the case may be, of the distributor or transferor corporation shall, subject to subparagraph (B), be deemed to have been received or incurred by the acquiring corporation as of the close of the date of the distribution or transfer; and

(B) a deficit in earnings and profits of the distributor, transferor, or acquiring corporation shall be used only to offset earnings and profits accumulated after the date of transfer. For this purpose, the earnings and profits for the taxable year of the acquiring corporation in which the distribution or transfer occurs shall be deemed to have been accumulated after such distribution or transfer in an amount which bears the same ratio to the undistributed earnings and profits of the acquiring corporation for such taxable year (computed without regard to any earnings and profits received from the distributor or transferor corporation, as described in subparagraph (A) of this paragraph) as the number of days in the taxable year after the date of distribution or transfer bears to the total number of days in the taxable year.

(3) CAPITAL LOSS CARRYOVER.—The capital loss carryover determined under section 1212, subject to the following conditions and limitations:

(A) The taxable year of the acquiring corporation to which the capital loss carryover of the distributor or transferor corporation is first carried shall be the first taxable year ending after the date of distribution or transfer.

(B) The capital loss carryover shall be a short-term capital loss in the taxable year determined under subparagraph (A) but shall be limited to an amount which bears the same ratio to the net capital gain (determined without regard to a short-term capital loss attributable to capital loss carryover), if any, of the acquiring corporation in such taxable year as the number of days in the taxable year after the date of distribution or transfer bears to the total number of days in the taxable year.

(C) For purposes of determining the amount of such capital loss carryover to taxable years following the taxable year determined under subparagraph (A), the net capital gain in the taxable year determined under subparagraph (A) shall be considered to be an amount equal to the amount determined under subparagraph (B).

(4) METHOD OF ACCOUNTING.—The acquiring corporation shall use the method of accounting used by the distributor or transferor corporation on the date of distribution or transfer unless different methods were used by several distributor or transferor corporations or by a distributor or transferor corporation and the acquiring corporation. If different methods were used, the acquiring corporation shall use the method or combination of methods of computing taxable income adopted pursuant to regulations prescribed by the Secretary or his delegate.

(5) INVENTORIES.—In any case in which inventories are received by the acquiring corporation, such inventories shall be taken by such corporation (in determining its income) on the same basis on which such inventories were taken by the distributor or transferor corporation, unless different methods were used by several distributor or transferor corporations or by a distributor or transferor corporation and the acquiring corporation. If different methods were used, the acquiring corporation shall use the method or combination of methods of taking inventory adopted pursuant to regulations prescribed by the Secretary or his delegate.

(6) METHOD OF COMPUTING DEPRECIATION ALLOWANCE.—The acquiring corporation shall be treated as the distributor or transferor corporation for purposes of computing the depreciation allowance under subsections (b), (j), and (k) of section 167 on property acquired in a distribution or transfer with respect to so much of the basis in the hands of the acquiring corporation as does not exceed the adjusted basis in the hands of the distributor or transferor corporation.

(7) [Deleted.]

(8) INSTALLMENT METHOD.—If the acquiring corporation acquires installment obligations (the income from which the distributor or transferor corporation has elected, under section 453, to report on the installment basis) the acquiring corporation shall, for purposes of section 453, be treated as if it were the distributor or transferor corporation.

(9) AMORTIZATION OF BOND DISCOUNT OR PREMIUM.—If the acquiring corporation assumes liability for bonds of the distributor or transferor corporation issued at a discount or premium, the acquiring corporation shall be treated as the distributor or transferor corporation after the date of distribution or transfer for purposes of determining the amount of amortization allowable or includible with respect to such discount or premium.

(10) **TREATMENT OF CERTAIN MINING EXPLORATION AND DEVELOPMENT EXPENSES OF DISTRIBUTOR OR TRANSFEROR CORPORATION.**—The acquiring corporation shall be entitled to deduct, as if it were the distributor or transferor corporation, expenses deferred under sections 615 and 616 (relating to pre-1970 exploration expenditures and development expenditures, respectively) if the distributor or transferor corporation has so elected. For the purpose of applying the limitation provided in section 615, if, for any taxable year, the distributor or transferor corporation was allowed the deduction in section 615 (a) or made the election in section 615 (b), the acquiring corporation shall be deemed to have been allowed such deduction or to have made such election, as the case may be. For the purpose of applying the limitation provided in section 617, if, for any taxable year, the distributor or transferor corporation was allowed the deduction in section 615(a) or section 617(a) or made the election provided in section 615(b), the acquiring corporation shall be deemed to have been allowed such deduction or deductions or to have made such election, as the case may be.

(11) **CONTRIBUTIONS TO PENSION PLANS, EMPLOYEES' ANNUITY PLANS, AND STOCK BONUS AND PROFIT-SHARING PLANS.**—The acquiring corporation shall be considered to be the distributor or transferor corporation after the date of distribution or transfer for the purpose of determining the amounts deductible under section 404 with respect to pension plans, employees' annuity plans, and stock bonus and profit-sharing plans.

(12) **RECOVERY OF BAD DEBTS, PRIOR TAXES, OR DELINQUENCY AMOUNTS.**—If the acquiring corporation is entitled to the recovery of bad debts, prior taxes, or delinquency amounts previously deducted or credited by the distributor or transferor corporation, the acquiring corporation shall include in its income such amounts as would have been includible by the distributor or transferor corporation in accordance with section 111 (relating to the recovery of bad debts, prior taxes, and delinquency amounts).

(13) **INVOLUNTARY CONVERSIONS UNDER SECTION 1033.**—The acquiring corporation shall be treated as the distributor or transferor corporation after the date of distribution or transfer for purposes of applying section 1033.

(14) **DIVIDEND CARRYOVER TO PERSONAL HOLDING COMPANY.**—The dividend carryover (described in section 564) to taxable years ending after the date of distribution or transfer.

(15) **INDEBTEDNESS OF CERTAIN PERSONAL HOLDING COMPANIES.**—The acquiring corporation shall be considered to be the distributor or transferor corporation for the purpose of determining the applicability of subsections (b)(7) and (c) of section 545, relating to deduction with respect to payment of certain indebtedness.

(16) **CERTAIN OBLIGATIONS OF DISTRIBUTOR OR TRANSFEROR CORPORATION.**—If the acquiring corporation—

(A) assumes an obligation of the distributor or transferor corporation which, after the date of the distribution or transfer, gives rise to a liability, and

(B) such liability, if paid or accrued by the distributor or transferor corporation, would have been deductible in computing its taxable income,

the acquiring corporation shall be entitled to deduct such items when paid or accrued, as the case may be, as if such corporation were the distributor or transferor corporation. A corporation which would have been an acquiring corporation under this section if the date of distribution or transfer had occurred on or after the effective date of the provisions of this subchapter applicable to a liquidation or reorganization, as the case may be, shall be entitled, even though the date of distribution or transfer occurred before such effective date, to apply this paragraph with respect to amounts paid or accrued in taxable years beginning after December 31, 1953, on account of such obligations of the distributor or transferor corporation. This paragraph shall not apply if such obligations are reflected in the amount of stock, securities, or property transferred by the acquiring corporation to the transferor corporation for the property of the transferor corporation.

(17) DEFICIENCY DIVIDEND OF PERSONAL HOLDING COMPANY.—If the acquiring corporation pays a deficiency dividend (as defined in section 547 (d)) with respect to the distributor or transferor corporation, such distributor or transferor corporation shall, with respect to such payments, be entitled to the deficiency dividend deduction provided in section 547.

(18) PERCENTAGE DEPLETION ON EXTRACTION OF ORES OR MINERALS FROM THE WASTE OR RESIDUE OF PRIOR MINING.—The acquiring corporation shall be considered to be the distributor or transferor corporation for the purpose of determining the applicability of section 613(c)(3) (relating to extraction of ores or minerals from the ground).

(19) CHARITABLE CONTRIBUTIONS IN EXCESS OF PRIOR YEARS' LIMITATIONS.—Contributions made in the taxable year ending on the date of distribution or transfer and the 4 prior taxable years by the distributor or transferor corporation in excess of the amount deductible under section 170(b)(2) for such taxable years shall be deductible by the acquiring corporation for its taxable years which begin after the date of distribution or transfer, subject to the limitations imposed in section 170(b)(2). In applying the preceding sentence, each taxable year of the distributor or transferor corporation beginning on or before the date of distribution or transfer shall be treated as a prior taxable year with reference to the acquiring corporation's taxable years beginning after such date.

(20) CARRY-OVER OF UNUSED PENSION TRUST DEDUCTIONS IN CERTAIN CASES.—Notwithstanding the other provisions of this section, or section 394(a), a corporation which has acquired the properties and assumed the liabilities of a wholly owned subsidiary shall be considered to have succeeded to and to be entitled to take into account contributions of the subsidiary to a pension plan, and shall be considered to be the distributor or transferor corporation after the date of distribution or transfer (but not for taxable years with respect to which this paragraph does not apply) for the purpose of determining the amounts deductible under section 404 with respect to contributions to a pension plan if—

(A) the corporate laws of the State of incorporation of the subsidiary required the surviving corporation in the case of merger to be incorporated under the laws of the State of incorporation of the subsidiary; and

(B) the properties were acquired in a liquidation of the subsidiary in a transaction subject to section 112(b)(6) of the Internal Revenue Code of 1939.

(21) **PRE-1954 ADJUSTMENTS RESULTING FROM CHANGE IN METHOD OF ACCOUNTING.**—The acquiring corporation shall take into account any net amount of any adjustment described in section 481(b)(4) of the distributor or transferor corporation—

(A) to the extent such net amount of such adjustment has not been taken into account by the distributor or transferor corporation, and

(B) in the same manner and at the same time as such net amount would have been taken into account by the distributor or transferor corporation.

(22) **SUCCESSOR INSURANCE COMPANY.**—If the acquiring corporation is an insurance company taxable under subchapter L, there shall be taken into account (to the extent proper to carry out the purposes of this section and of subchapter L, and under such regulations as may be prescribed by the Secretary or his delegate) the items required to be taken into account for purposes of subchapter L in respect of the distributor or transferor corporation.

(23) **CREDIT UNDER SECTION 38 FOR INVESTMENT IN CERTAIN DEPRECIABLE PROPERTY.**—The acquiring corporation shall take into account (to the extent proper to carry out the purposes of this section and section 38, and under such regulations as may be prescribed by the Secretary or his delegate) the items required to be taken into account for purposes of section 38 in respect of the distributor or transferor corporation.

(24) **CREDIT UNDER SECTION 40 FOR [WORK INCENTIVE] GUARANTEED EMPLOYMENT PROGRAM EXPENSES.**—The acquiring corporation shall take into account (to the extent proper to carry out the purposes of this section and section 40, and under such regulations as may be prescribed by the Secretary or his delegate) the items required to be taken into account for purposes of section 40 in respect of the distributor or transferor corporation.

(d) **OPERATIONS LOSS CARRYBACKS AND CARRYOVERS OF LIFE INSURANCE COMPANIES.**—

For application of this part to operations loss carrybacks and carryovers of life insurance companies, see section 812(f).

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SEC. 383. SPECIAL LIMITATIONS ON CARRYOVERS OF UNUSED INVESTMENT CREDITS, [WORK INCENTIVE] GUARANTEED EMPLOYMENT PROGRAM CREDITS, FOREIGN TAXES, AND CAPITAL LOSSES.

If—

(1) the ownership and business of a corporation are changed in the manner described in section 382(a)(1), or

(2) in the case of a reorganization specified in paragraph (2) of section 381(a), there is a change in ownership described in section 382(b)(1)(B),

then the limitations provided in section 382 in such cases with respect to the carryover of net operating losses shall apply in the same manner, as provided under regulations prescribed by the Secretary or his

delegate, with respect to any unused investment credit of the corporation which can otherwise be carried forward under section 46(b), to any unused [work incentive] *guaranteed employment* program credit of the corporation which can otherwise be carried forward under section 50A(b), to any excess foreign taxes of the corporation which can otherwise be carried forward under section 904(d), and to any net capital loss of the corporation which can otherwise be carried forward under section 1212.

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Subchapter N—Tax Based on Income From Sources Within or Without the United States

Part I. Determination of sources of income.
Part II. Nonresident aliens and foreign corporations.
Part III. Income from sources without the United States.

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PART III—INCOME FROM SOURCES WITHOUT THE UNITED STATES

Subpart A. Foreign tax credit.
Subpart B. Earned income of citizens of United States.
Subpart C. Western Hemisphere trade corporations.
Subpart D. Possessions of the United States.
Subpart E. China Trade Act corporations.
Subpart F. Controlled Foreign Corporations.
Subpart G. Export Trade Corporations.

Subpart A—Foreign Tax Credit

Sec. 901. Taxes of foreign countries and of possessions of United States.
Sec. 902. Credit for corporate stockholder in foreign corporation.
Sec. 903. Credit for taxes in lieu of income, etc., taxes.
Sec. 904. Limitation on credit.
Sec. 905. Applicable rules.
Sec. 906. Nonresident alien individuals and foreign corporations.

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SEC. 904. LIMITATION ON CREDIT.

(a) ALTERNATIVE LIMITATIONS.—

(1) **PER-COUNTRY LIMITATION.**—In the case of any taxpayer who does not elect the limitation provided by paragraph (2), the amount of the credit in respect of the tax paid or accrued to any foreign country or possession of the United States shall not exceed the same proportion of the tax against which such credit is taken which the taxpayer's taxable income from sources within such country or possession (but not in excess of the taxpayer's entire taxable income) bears to his entire taxable income for the same taxable year.

(2) **OVERALL LIMITATION.**—In the case of any taxpayer who elects the limitation provided by this paragraph, the total amount of the credit in respect of taxes paid or accrued to all foreign countries and possessions of the United States shall not exceed the same proportion of the tax against which such credit is taken which the taxpayer's taxable income from sources without the United States

(but not in excess of the taxpayer's entire taxable income) bears to his entire taxable income for the same taxable year.

(b) ELECTION OF OVERALL LIMITATION.—

(1) **IN GENERAL.**—A taxpayer may elect the limitation provided by subsection (a)(2) for any taxable year beginning after December 31, 1960. An election under this paragraph for any taxable year shall remain in effect for all subsequent taxable years, except that it may be revoked (A) with the consent of the Secretary or his delegate with respect to any taxable year or (B) for the taxpayer's first taxable year beginning after December 31, 1969.

(2) **ELECTION AFTER REVOCATION.**—Except in a case to which paragraph (1)(B) applies, if the taxpayer has made an election under paragraph (1) and such election has been revoked, such taxpayer shall not be eligible to make a new election under paragraph (1) for any taxable year, unless the Secretary or his delegate consents to such new election.

(3) **FORM AND TIME OF ELECTION AND REVOCATION.**—An election under paragraph (1), and any revocation of such an election, may be made only in such manner as the Secretary or his delegate may by regulations prescribe. Such an election or revocation with respect to any taxable year may be made or changed at any time before the expiration of the period prescribed for making a claim for credit or refund of the tax imposed by this chapter for such taxable year.

(c) TAXABLE INCOME FOR PURPOSE OF COMPUTING LIMITATION.—For purposes of computing the applicable limitation under subsection (a), the taxable income in the case of an individual, estate, or trust shall be computed without any deduction for personal exemptions under section 151 or 642(b).

(d) CARRYBACK AND CARRYOVER OF EXCESS TAX PAID.—Any amount by which any such tax paid or accrued to any foreign country or possession of the United States for any taxable year beginning after December 31, 1957, for which the taxpayer chooses to have the benefits of this subpart exceeds the applicable limitation under subsection (a) shall be deemed tax paid or accrued to such foreign country or possession of the United States in the second preceding taxable year, in the first preceding taxable year, and in the first, second, third, fourth, or fifth succeeding taxable years, in that order and to the extent not deemed tax paid or accrued in a prior taxable year, in the amount by which the applicable limitation under subsection (a) for such preceding or succeeding taxable year exceeds the sum of the tax paid or accrued to such foreign country or possession for such preceding or succeeding taxable year and the amount of the tax for any taxable year earlier than the current taxable year which shall be deemed to have been paid or accrued in such preceding or subsequent taxable year (whether or not the taxpayer chooses to have the benefits of this subpart with respect to such earlier taxable year). Such amount deemed paid or accrued in any year may be availed of only as a tax credit and not as a deduction and only if taxpayer for such year chooses to have the benefits of this subpart as to taxes paid or accrued for that year to foreign countries or possessions. For purposes of this subsection, the terms "second preceding taxable year" and "first preceding taxable year" do not include any taxable year beginning before January 1, 1958.

(e) CARRYBACKS AND CARRYOVERS WHERE OVERALL LIMITATION IS ELECTED.—

(1) FOREIGN TAXES TO BE AGGREGATED FOR PURPOSES OF SUBSECTION (d).—With respect to each taxable year of the taxpayer to which the limitation provided by subsection (a)(2) applies, the taxes referred to in the first sentence of subsection (d) shall, for purposes of applying such first sentence, be aggregated on an overall basis (rather than taken into account on a per-country basis).

(2) FOREIGN TAXES MAY NOT BE CARRIED FROM PER-COUNTRY YEAR TO OVERALL YEAR OR FROM OVERALL YEAR TO PER-COUNTRY YEAR.—No amount paid or accrued for any taxable year to which the limitation provided by subsection (a)(1) applies shall (except for purposes of determining the number of taxable years which have elapsed) be deemed paid or accrued under subsection (d) in any taxable year to which the limitation provided by subsection (a)(2) applies. No amount paid or accrued for any taxable year to which the limitation provided by subsection (a)(2) applies shall (except for purposes of determining the number of taxable years which have elapsed) be deemed paid or accrued under subsection (d) in any taxable year to which the limitation provided by subsection (a)(1) applies.

(f) APPLICATION OF SECTION IN CASE OF CERTAIN INTEREST INCOME AND DIVIDENDS FROM A DISC OR FORMER DISC.—

(1) IN GENERAL.—The provisions of subsections (a), (c), (d), and (e) of this section shall be applied separately with respect to each of the following items of income—

(A) the interest income described in paragraph (2),

(B) dividends from a DISC or former DISC (as defined in section 992(a)) to the extent such dividends are treated as income from sources without the United States, and

(C) income other than the interest income described in paragraph (2) and dividends described in subparagraph (B).

(2) INTEREST INCOME TO WHICH APPLICABLE.—For purposes of this subsection, the interest income described in this paragraph is interest other than interest—

(A) derived from any transaction which is directly related to the active conduct of a trade or business in a foreign country or a possession of the United States,

(B) derived in the conduct of a banking, financing, or similar business,

(C) received from a corporation in which the taxpayer (or one or more includible corporations in an affiliated group, as defined in section 1504, of which the taxpayer is a member) owns, directly or indirectly, at least 10 percent of the voting stock,

(D) received on obligations acquired as a result of the disposition of a trade or business actively conducted by the taxpayer in a foreign country or possession of the United States or as a result of the disposition of stock or obligations of a corporation in which the taxpayer owned at least 10 percent of the voting stock.

For purposes of subparagraph (C), stock owned, directly or indirectly, by or for a foreign corporation shall be considered as being proportionately owned by its shareholders.

(3) OVERALL LIMITATION NOT TO APPLY.—The limitation provided

by subsection (a)(2) shall not apply with respect to the interest income described in paragraph (2) or to dividends described in paragraph (1)(B). The Secretary or his delegate shall by regulations prescribe the manner of application of subsection (e) with respect to cases in which the limitation provided by subsection (a)(2) applies with respect to income described in paragraph (1) (B) and (C).

(4) TRANSITIONAL RULES FOR CARRYBACKS AND CARRYOVERS.—

(A) CARRYBACKS TO YEARS PRIOR TO REVENUE ACT OF 1962.—

Where, under the provisions of subsection (d), taxes (i) paid or accrued to any foreign country or possession of the United States in any taxable year beginning after the date of the enactment of the Revenue Act of 1962 are deemed (ii) paid or accrued in one or more taxable years beginning on or before the date of enactment of the Revenue Act of 1962, the amount of such taxes deemed paid or accrued shall be determined without regard to the provisions of this subsection. To the extent the taxes paid or accrued to a foreign country or possession of the United States in any taxable year described in clause (i) are not, with the application of the preceding sentence, deemed paid or accrued in any taxable year described in clause (ii), such taxes shall, for purposes of applying subsection (d), be deemed paid or accrued in a taxable year beginning after the date of the enactment of the Revenue Act of 1962, with respect to interest income described in paragraph (2), and with respect to income other than interest income described in paragraph (2), in the same ratios as the amount of such taxes paid or accrued with respect to interest income described in paragraph (2), and the amount of such taxes paid or accrued with respect to income other than interest income described in paragraph (2), respectively, bear to the total amount of such taxes paid or accrued to such foreign country or possession of the United States.

(B) CARRYOVERS TO YEARS AFTER REVENUE ACT OF 1962.—

Where, under the provisions of subsection (d), taxes (i) paid or accrued to any foreign country or possession of the United States in any taxable year beginning on or before the date of the enactment of the Revenue Act of 1962 are deemed (ii) paid or accrued in one or more taxable years beginning after the date of the enactment of the Revenue Act of 1962, the amount of such taxes deemed paid or accrued in any year described in clause (ii) shall, with respect to interest income described in paragraph (2), be an amount which bears the same ratio to the amount of such taxes deemed paid or accrued as the amount of the taxes paid or accrued to such foreign country or possession for such year with respect to interest income described in paragraph (2) bears to the total amount of the taxes paid or accrued to such foreign country or possession for such year; and the amount of such taxes deemed paid or accrued in any year described in clause (ii) with respect to income other than interest income described in paragraph (2) shall be an amount which bears the same ratio to the amount of such taxes deemed paid or accrued for such year as the amount of taxes paid or accrued to such foreign country or possession for such year with respect to income other than interest income

described in paragraph (2) bears to the total amount of the taxes paid or accrued to such foreign country or possession for such year.

(5) **DISC DIVIDENDS AGGREGATED FOR PURPOSES OF PER-COUNTRY LIMITATION.**—In the case of a taxpayer who for the taxable year has dividends described in paragraph (1)(B) from more than one corporation, the limitation provided by subsection (a)(1) shall be applied with respect to the aggregate of such dividends.

(g) **COORDINATION WITH CREDIT FOR RETIREMENT INCOME.**—*In the case of an individual, for purposes of subsection (a) the tax against which the credit is taken is such tax reduced by the amount of the credit (if any) for the taxable year allowable under section 37 (relating to retirement income).*

[(g)] (h) **CROSS REFERENCE.**—

(1) For increase of applicable limitation under subsection (a) for taxes paid with respect to amounts received which were included in the gross income of the taxpayer for a prior taxable year as a United States shareholder with respect to a controlled foreign corporation, see section 960(b).

(2) For special rule relating to the application of the credit provided by section 901 in the case of affiliated groups which include Western Hemisphere trade corporations for years in which the limitation provided by subsection (a)(2) applies, see section 1503(b).

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CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

Sec. 1401. Rate of tax.
Sec. 1402. Definitions.
Sec. 1403. Miscellaneous provisions.

SEC. 1401. RATE OF TAX.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1969, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1971, the tax shall be equal to 6.3 percent of the amount of the self-employment income for such taxable year;

(3) in the case of any taxable year beginning after December 31, 1970, and before January 1, [1978] 1978, the tax shall be equal to 6.9 percent of the amount of the self-employment income for such taxable year;

[(4)] (4) in the case of any taxable year beginning after December 31, 1977, and before January 1, 2011, the tax shall be equal to 6.7 percent of the amount of the self-employment income for such taxable year; and

[(5)] (4) in the case of any taxable year beginning after December

31, ~~2010~~, 1972 the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1973, the tax shall be equal to 0.60 percent of the amount of the self-employment income for such taxable year;

(2) in the case of any taxable year beginning after December 31, 1972, and before January 1, 1978, the tax shall be equal to ~~0.9~~ 1.1 percent of the amount of the self-employment income for such taxable year;

(3) in the case of any taxable year beginning after December 31, 1977, and before January 1, ~~1986~~ 1981, the tax shall be equal to ~~1.0~~ 1.3 percent of the amount of the self-employment income for such taxable year;

(4) in the case of any taxable year beginning after December 31, ~~1985~~ 1980, and before January 1, 1993, the tax shall be equal to ~~1.1~~ 1.5 percent of the amount of the self-employment income for such taxable year; and

(5) in the case of any taxable year beginning after December 31, 1992, the tax shall be equal to ~~1.2~~ 1.6 percent of the amount of the self-employment income for such taxable year.

SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT.—The term “net earnings from self-employment” means the gross income derived by an individual from any trade or business carried on by such individual, less the deductions allowed by this subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of income or loss described in section 702(a)(9) from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary income or loss—

(1) there shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares) together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant with respect to any such agricultural or horticultural commodity;

(2) there shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered

form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest (other than interest described in section 35) are received in the course of a trade or business as a dealer in stocks or securities;

(3) there shall be excluded any gain or loss—

(A) which is considered as gain or loss from the sale or exchange of a capital asset,

(B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 applies to such gain or loss or

(C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither—

(i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor

(ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) the deduction for net operating losses provided in section 172 shall not be allowed;

(5) if—

(A) any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife; and

(B) any portion of a partner's distributive share of the ordinary income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) a resident of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to section 933;

(7) the deduction for personal exemptions provided in section 151 shall not be allowed;

(8) an individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages) [and], section 119 (relating to meals and lodging furnished for the convenience of the employer) [and, in addition, if he is a citizen of the United States performing such service as an employee of an American employer (as defined in section 3121(h)) or as a minister in a foreign country who has a congregation which is composed predominantly of citizens of the United States, without regard to].

section 911 (relating to earned income from sources without the United States) and section 931 (relating to income from sources within possessions of the United States);

(9) the term "possession of the United States" as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) shall be deemed not to include the Virgin Islands, Guam, or American Samoa; **[and]**

(10) there shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary or his delegate, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A) **[.]**; and

(11) in the case of an individual who has been a resident of the United States during the entire taxable year, the exclusion from gross income provided by section 911(a)(2) shall not apply.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based on the ordinary income or loss of the partnership for any taxable year of the partnership ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 3121(g)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than \$2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66% percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than \$2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than \$1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be \$1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the

sum of all payments to which section 707(c) applies) is not more than \$2,400, his distributive share of income described in section 702(a)(9) derived from such trade or business may, at his option, be deemed to be an amount equal to 66⅔ percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is more than \$2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(9) derived from such trade or business (computed under this subsection without regard to this sentence) is less than \$1,600, his distributive share of income described in section 702(a)(9) derived from such trade or business may, at his option, be deemed to be \$1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection; and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (i), or by a partnership of which an individual is a member on a regular basis as defined in subsection (i), but only if such individual's net earnings from self-employment as determined without regard to this sentence in the taxable year are less than \$1,600 and less than 66⅔ percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed \$1,600.

(b) **SELF-EMPLOYMENT INCOME.**—The term “self-employment income” means the net earnings from self-employment derived by an individual (other than a nonresident alien individual) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of—

(A) for any taxable year ending prior to 1955, (i) \$3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) for any taxable year ending after 1954 and before 1959, (i) \$4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) for any taxable year ending after 1958 and before 1966, (i) \$4,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(D) for any taxable year ending after 1965 and before 1968, (i) \$6,600, minus (ii) the amount of wages paid to such individual during the taxable year; and

(E) for any taxable year ending after 1967 and beginning before 1972, (i) \$7,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(F) for any taxable year beginning after 1971 and before 1973, (i) \$9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(G) for any taxable year beginning after 1972 and before 1974, (i) \$10,800, minus (ii) the amount of wages paid to such individual during the taxable year; and

(H) for any taxable year beginning after 1973 and before 1975, (i) \$12,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(I) for any taxable year beginning in any calendar year after 1974, (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than \$400.

For purposes of clause (1), the term “wages” (A) includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or under an agreement entered into pursuant to the provisions of section 3121 (l) (relating to coverage of citizens of the United States who are employees of foreign subsidiaries of domestic corporations), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), and (B) includes, but solely with respect to the tax imposed by section 1401(b), compensation which is subject to the tax imposed by section 3201 or 3211. An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual.

(c) **TRADE OR BUSINESS.**—The term “trade or business”, when used with reference to self-employment income or net earnings from self-

employment, shall have the same meaning as when used in section 162 (relating to trade or business expenses), except that such term shall not include—

(1) the performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Secretary of Health, Education, and Welfare pursuant to section 218 of the Social Security Act;

(2) the performance of service by an individual as an employee, other than—

(A) service described in section 3121(b)(14)(B) performed by an individual who has attained the age of 18,

(B) service described in section 3121(b)(16),

(C) service described in section 3121(b)(11), (12), or (15) performed in the United States (as defined in section 3121(e)(2)) by a citizen of the United States,

(D) service described in paragraph (4) of this subsection, and

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Secretary of Health, Education, and Welfare pursuant to section 218 of the Social Security Act;

(3) the performance of service by an individual as an employee or employee representative as defined in section 3231;

(4) the performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) the performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) the performance of service by an individual during the period for which an exemption under subsection (h) is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under subsection (e) is effective with respect to him.

(d) **EMPLOYEE AND WAGES.**—The term “employee” and the term “wages” shall have the same meaning as when used in chapter 21 (sec. 3101 and following, relating to Federal Insurance Contributions Act).

(e) **MINISTERS, MEMBERS OF RELIGIOUS ORDERS, AND CHRISTIAN SCIENCE PRACTITIONERS.**—

(1) **EXEMPTION.**—Any individual who is (A) a duly ordained, commissioned, or licensed minister of a church or a member of a religious order (other than a member of a religious order who has taken a vow of poverty as a member of such order) or (B) a Christian Science practitioner, upon filing an application (in such form and manner, and with such official, as may be prescribed by regulations

made under this chapter) together with a statement that either he is conscientiously opposed to, or because of religious principles he is opposed to, the acceptance (with respect to services performed by him as such minister, member, or practitioner) of any public insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act), shall receive an exemption from the tax imposed by this chapter with respect to services performed by him as such minister, member, or practitioner. Notwithstanding the preceding sentence, an exemption may not be granted to an individual under this subsection if he had filed an effective waiver certificate under this section as it was in effect before its amendment in 1967.

(2) **TIME FOR FILING APPLICATION.**—Any individual who desires to file an application pursuant to paragraph (1) must file such application on or before whichever of the following dates is later: (A) the due date of the return (including any extension thereof) for the second taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of \$400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or (B) the due date of the return (including any extension thereof) for his second taxable year ending after 1967.

(3) **EFFECTIVE DATE OF EXEMPTION.**—An exemption received by an individual pursuant to this subsection shall be effective for the first taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of \$400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5), and for all succeeding taxable years. An exemption received pursuant to this subsection shall be irrevocable.

(f) **PARTNER'S TAXABLE YEAR ENDING AS THE RESULT OF DEATH.**—In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

(g) **TREATMENT OF CERTAIN REMUNERATION ERRONEOUSLY REPORTED AS NET EARNINGS FROM SELF-EMPLOYMENT.**—If—

(1) an amount is erroneously paid as tax under section 1401, for any taxable year ending after 1954 and before 1962, with respect to

remuneration for service described in section 3121(b)(8) (other than service described in section 3121(b)(8)(A)), and such remuneration is reported as self-employment income on a return filed on or before the due date prescribed for filing such return (including any extension thereof),

(2) the individual who paid such amount (or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act)) requests that such remuneration be deemed to constitute net earnings from self-employment,

(3) such request is filed after the date of the enactment of this paragraph and on or before April 15, 1962,

(4) such remuneration was paid to such individual for services performed in the employ of an organization which, on or before the date on which such request is filed, has filed a certificate pursuant to section 3121(k), and

(5) no credit or refund of any portion of the amount erroneously paid for such taxable year as tax under section 1401 (other than a credit or refund which would be allowable if such tax were applicable with respect to such remuneration) has been obtained before the date on which such request is filed or, if obtained, the amount credited or refunded (including any interest under section 6611) is repaid on or before such date,

then, for purposes of this chapter and chapter 21, any amount of such remuneration which is paid to such individual before the calendar quarter in which such request is filed (or before the succeeding quarter if such certificate first becomes effective with respect to services performed by such individual in such succeeding quarter), and with respect to which no tax (other than an amount erroneously paid as tax) has been paid under chapter 21, shall be deemed to constitute net earnings from self-employment and not remuneration for employment. For purposes of section 3121(b)(8)(B) (ii) and (iii), if the certificate filed by such organization pursuant to section 3121(k) is not effective with respect to services performed by such individual on or before the first day of the calendar quarter in which the request is filed, such individual shall be deemed to have become an employee of such organization (or to have become a member of a group described in section 3121(k)(1)(E)) on the first day of the succeeding quarter.

(h) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

(1) EXEMPTION.—Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof

as the Secretary or his delegate may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person, and only if the Secretary of Health, Education, and Welfare finds that—

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

(2) **TIME FOR FILING APPLICATION.**—For purposes of this subsection, an application must be filed—

(A) in the case of an individual who has self-employment income (determined without regard to this subsection and subsection (c)(6)) for any taxable year ending before December 31, 1967, on or before December 31, 1968, and

(B) in any other case, on or before the time prescribed for filing the return (including any extension thereof) for the first taxable year ending on or after December 31, 1967, for which he has self-employment income (as so determined), except that an application filed after such date but on or before the last day of the third calendar month following the calendar month in which the taxpayer is first notified in writing by the Secretary or his delegate that a timely application for an exemption from the tax imposed by this chapter has not been filed by him shall be deemed to be filed timely.

(3) **PERIOD FOR WHICH EXEMPTION EFFECTIVE.**—An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year—

(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of paragraph (1), or (ii) before the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Secretary of Health, Education, and

Welfare finds that the sect or division thereof of which he is a member ceases to meet the requirements of subparagraph (C) or (D).

(4) APPLICATION BY FIDUCIARIES OR SURVIVORS.—In any case where an individual who has self-employment income dies before the expiration of the time prescribed by paragraph (2) for filing an application for exemption pursuant to this subsection, such an application may be filed with respect to such individual within such time by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act).

REGULAR BASIS

(i) *An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than \$400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.*

* * * * *

Subtitle C—Employment Taxes

CHAPTER 21. Federal insurance contributions act.
CHAPTER 22. Railroad retirement tax act.
CHAPTER 23. Federal unemployment tax act.
CHAPTER 24. Collection of income tax at source on wages.
CHAPTER 25. General provisions relating to employment taxes.

CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

SUBCHAPTER A. Tax on employees.
SUBCHAPTER B. Tax on employers.
SUBCHAPTER C. General provisions.

Subchapter A—Tax on Employees

Sec. 3101. Rate of tax.
Sec. 3102. Deduction of tax from wages.

SEC. 3101. RATE OF TAX.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

- (1) with respect to wages received during the calendar year 1968, the rate shall be 3.8 percent;
- (2) with respect to wages received during the calendar years 1969 and 1970, the rate shall be 4.2 percent;
- (3) with respect to wages received during [any of] the calendar years 1971 [through 1977] and 1972, the rate shall be 4.6 percent;

(4) *with respect to wages received during the calendar years 1973, 1974, 1975, 1976, and 1977, the rate shall be 4.9 percent;*

[(4)] (5) *with respect to wages received during [any of] the calendar years 1978 through 2010, the rate shall be [4.5] 4.95 percent; and*

[(5)] (6) *with respect to wages received after December 31, 2010, the rate shall be [5.35] 6.05 percent.*

(b) **HOSPITAL INSURANCE.**—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

(1) *with respect to wages paid during the calendar years 1968, 1969, 1970, 1971, and 1972, the rate shall be 0.60 percent;*

(2) *with respect to wages received during the calendar years 1973, 1974, 1975, 1976, and 1977, the rate shall be [0.9] 1.1 percent;*

(3) *with respect to wages received during the calendar years 1978, 1979, and 1980, [1981, 1982, 1983, 1984, and 1985,] the rate shall be [1.0] 1.3 percent.*

(4) *with respect to wages received during the calendar years 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, and 1992, the rate shall be [1.1] 1.5 percent; and*

(5) *with respect to wages received after December 31, 1992, the rate shall be [1.2] 1.6 percent.*

* * * * *

Subchapter B—Tax on Employers

Sec. 3111. Rate of tax.

Sec. 3112. Instrumentalities of the United States.

Sec. 3113. District of Columbia credit unions.

SEC. 3111. RATE OF TAX.

(a) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

(1) *with respect to wages paid during the calendar year 1968, the rate shall be 3.8 percent;*

(2) *with respect to wages paid during the calendar years 1969 and 1970, the rate shall be 4.2 percent;*

(3) *with respect to wages paid during [any of] the calendar years 1971 [through 1977] and 1972, the rate shall be 4.6 percent;*

(4) *with respect to wages received during the calendar years 1973, 1974, 1975, 1976, and 1977, the rate shall be 4.9 percent;*

[(4)] (5) *with respect to wages paid during [any of] the calendar years 1978 through 2010, the rate shall be [4.5] 4.95 percent; and*

[(5)] (6) *with respect to wages paid after December 31, 2010, the rate shall be [5.35] 6.05 percent.*

(b) **HOSPITAL INSURANCE.**—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an

excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

- (1) with respect to wages paid during the calendar years 1968, 1969, 1970, 1971, and 1972, the rate shall be 0.60 percent;
- (2) with respect to wages paid during the calendar years 1973, 1974, 1975, 1976, and 1977, the rate shall be **[0.9]** 1.1 percent;
- (3) with respect to wages paid during the calendar years 1978, 1979, and 1980, **[1981, 1982, 1983, 1984, and 1985,]** the rate shall be **[1.0]** 1.3 percent;
- (4) with respect to wages paid during the calendar years 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, and 1992, the rate shall be **[1.1]** 1.5 percent; and
- (5) with respect to wages paid after December 31, 1992, the rate shall be **[1.2]** 1.6 percent.

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Subchapter C—General Provisions

- Sec. 3121. Definitions.
 Sec. 3122. Federal service.
 Sec. 3123. Deductions as constructive payments.
 Sec. 3124. Estimate of revenue reduction.
 Sec. 3125. Returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia.
 Sec. 3126. Short title.

SEC. 3121. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term “wages” means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term shall not include—

* * * * *

(9) any payment (other than vacation or sick pay) made to an employee after the month in which—

[(A) in the case of a man, he attains the age of 65, or
(B) in the case of a woman, she attains the age of 62,]**
he attains age 62, if such employee did not work for the employer in the period for which such payment is made;**

(10) remuneration paid by an employer in any calendar quarter to an employee for service described in subsection (d) (3) (C) (relating to home workers), if the cash remuneration paid in such quarter by the employer to the employee for such service is less than \$50;

(11) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217;

(12) (A) tips paid in any medium other than cash;

(B) cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is \$20 or more; **[or]**

(13) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, (ii) retirement for disability, or (iii) retirement after attaining an age specified in the plan referred to in subparagraph (B) or in a pension plan of the employer, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated[.];

(14) *any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died; or*

(15) *any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) of the Social Security Act and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period during which such payment is made.*

(b) **EMPLOYMENT.**—For the purposes of this chapter, the term “employment” means any service performed after 1936 and prior to 1955 which was employment for purposes of subchapter A of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1954 either (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen of the United States as an employee for an American employer (as defined in subsection (h)); except that, in the case of service performed after 1954, such term shall not include—

(1) service performed by foreign agricultural workers (A) under contracts entered into in accordance with title V of the Agricultural Act of 1949, as amended (65 Stat. 119; 7 U.S.C. 1461-1468), or (B) lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3) (A) service performed by an individual in the employ of his

spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft, when outside the United States and (B) (i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) service performed in the employ of any instrumentality of the United States, if such instrumentality is exempt from the tax imposed by section 3111 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;

(6) (A) service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is covered by a retirement system established by a law of the United States;

(B) service performed by an individual in the employ of an instrumentality of the United States if such an instrumentality was exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939 on December 31, 1950, and if such service is covered by a retirement system established by such instrumentality; except that the provisions of this subparagraph shall not be applicable to—

(i) service performed in the employ of a corporation which is wholly owned by the United States;

(ii) service performed in the employ of a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Home Loan Bank, or a Federal Credit Union;

(iii) service performed in the employ of a State, county, or community committee under the Commodity Stabilization Service;

(iv) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and

Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; or-

(v) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of the Treasury, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;

(C) service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is performed—

(i) as the President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress;

(ii) in the legislative branch;

(iii) in a penal institution of the United States by an inmate thereof;

(iv) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government) other than as a medical or dental intern or a medical or dental resident in training;

(v) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

(vi) by any individual to whom subchapter III of chapter 83 of title 5, United States Code, does not apply because such individual is subject to another retirement system (other than the retirement system of the Tennessee Valley Authority);

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service which, under subsection (j), constitutes covered transportation service,

(B) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title with respect to the taxes imposed by this chapter—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate, **[or]**

(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by an individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis**[,]**, or

(D) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (B) shall apply;

(8) (A) service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, *except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under subsection (r) is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;*

(B) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c) (3) which is exempt from income tax under section 501(a), but this subparagraph shall not apply to service performed during the period for which a certificate, filed pursuant to subsection (k) (or the corresponding subsection of prior law), is in effect if such service is performed by an employee—

(i) whose signature appears on the list filed by such organization under subsection (k) (or the corresponding subsection of prior law),

(ii) who became an employee of such organization after the calendar quarter in which the certificate (other than a certificate referred to in clause (iii)) was filed, or

(iii) who, after the calendar quarter in which the certificate was filed with respect to a group described in section 3121(k)(1)(E), became a member of such group, except that this subparagraph shall apply with respect to service performed by an employee as a member of a group described in section 3121(k)(1)(E) with respect to which no certificate is in effect;

(9) service performed by an individual as an employee or employee representative as defined in section 3231;

(10) (A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521, if the remuneration for such service is less than \$50;

[(B) service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university:]

(B) service performed in the employ of—

(i) a school, college, or university, or

(ii) an organization described in section 509(a)(3) 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 with such school, college, or university, 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 Social Security Act are covered under the agreement between the Secretary of Health, Education, and Welfare and such State entered into pursuant to section 218 of such Act; if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a non-diplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14) (A) service performed by an individual under the age of 18

in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) service performed in the employ of an international organization;

(16) service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) service in the employ of any organization which is performed (A) in any quarter during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a communist-infiltrated organization, and (B) after June 30, 1956;

(18) service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigrant and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)); or

(19) service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be.

(c) INCLUDED AND EXCLUDED SERVICE.—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than 31 consecutive days) for which a payment of re-

muneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (b) (9).

(d) **EMPLOYEE.**—For purposes of this chapter, the term “employee” means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2)) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term “employee” under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

(e) **STATE, UNITED STATES, AND CITIZEN.**—For purposes of this chapter—

(1) **STATE.**—The term “State” includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(2) **UNITED STATES.**—The term “United States” when used in a geographical sense includes the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.

(f) **AMERICAN VESSEL AND AIRCRAFT.**—For purposes of this chapter, the term “American vessel” means any vessel documented or num-

bered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term "American aircraft" means an aircraft registered under the laws of the United States.

(g) AGRICULTURAL LABOR.—For purposes of this chapter, the term "agricultural labor" includes all service performed—

(1) on a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training and management of livestock, bees, poultry, and fur-bearing animals and wildlife;

(2) in the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm;

(3) in connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15 (g) of the Agricultural Marketing Act, as amended (46 Stat. 1550, § 3; 12 U.S.C. 1141j), or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes;

(4) (A) in the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed;

(B) in the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than 20 at any time during the calendar quarter in which such service is performed;

(C) the provisions of subparagraphs (A) and (B) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption; or

(5) on a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

As used in this subsection, the term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures

used primarily for the raising of agricultural or horticultural commodities, and orchards.

(h) **AMERICAN EMPLOYER.**—For purposes of this chapter, the term “American employer” means an employer which is—

- (1) the United States or any instrumentality thereof,
- (2) an individual who is a resident of the United States,
- (3) a partnership, if two-thirds or more of the partners are residents of the United States,
- (4) a trust, if all of the trustees are residents of the United States, or
- (5) a corporation organized under the laws of the United States or of any State.

(i) **COMPUTATION OF WAGES IN CERTAIN CASES.**—

(1) **DOMESTIC SERVICE.**—For purposes of this chapter, in the case of domestic service described in subsection (a) (7) (B), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this chapter, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to \$1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a) (7) (B).

(2) **SERVICE IN THE UNIFORMED SERVICES.**—For purposes of this chapter, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of subsection (m) (1) are applicable, the term “wages” shall, subject to the provisions of subsection (a) (1) of this section, include as such individual’s remuneration for such service only his basic pay as described in section 102(10) of the Servicemen’s and Veterans’ Survivor Benefits Act.

(3) **PEACE CORPS VOLUNTEER SERVICE.**—For purposes of this chapter in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the term “wages” shall, subject to the provisions of subsection (a) (1) of this section, include as such individual’s remuneration for such service only amounts paid pursuant to section 5(c) or 6(1) of the Peace Corps Act.

(4) **SERVICE PERFORMED BY CERTAIN MEMBERS OF RELIGIOUS ORDERS.**—*For purposes of this chapter, in any case where an individual is a member of a religious order (as defined in subsection (r) (2)) performing service in the exercise of duties required by such order, and an election of coverage under subsection (r) is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term “wages” shall, subject to the provisions of subsection (a) (1), include as such individual’s remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to*

an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than \$100 a month.

(j) COVERED TRANSPORTATION SERVICE.—For purposes of this chapter—

(1) EXISTING TRANSPORTATION SYSTEMS—GENERAL RULE.—Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951

(2) EXISTING TRANSPORTATION SYSTEMS—CASES IN WHICH NO TRANSPORTATION EMPLOYEES, OR ONLY CERTAIN EMPLOYEES, ARE COVERED.—Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system was, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951; except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment (including as employment service covered by an agreement under section 218 of the Social Security Act) in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) TRANSPORTATION SYSTEMS ACQUIRED AFTER 1950.—All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or

political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) DEFINITIONS.—For purposes of this subsection—

(A) The term “general retirement system” means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this chapter or subchapter A of chapter 9 of the Internal Revenue Code of 1939 or was covered by an agreement made pursuant to section 218 of the Social Security Act and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term “political subdivision” includes an instrumentality of—

- (i) a State,
- (ii) one or more political subdivisions of a State, or
- (iii) a State and one or more of its political subdivisions.

(k) EXEMPTION OF RELIGIOUS, CHARITABLE, AND CERTAIN OTHER ORGANIZATIONS.—

(1) WAIVER OF EXEMPTION BY ORGANIZATION.—

(A) An organization described in section 501(c)(3) which is exempt from income tax under section 501(a) may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations made under this chapter) certifying that it desires to have the insurance system established by title II of the Social Security Act extended to service performed by its employees. Such certificate may be filed only if it is accompanied by a list containing the signature, address, and social security account number (if any) of each employee (if any) who concurs in the filing of the certificate. Such list may be amended at any time prior to the expiration of the twenty-fourth month following the calendar quarter in which the certificate is filed by filing with the prescribed official a supplemental list or lists containing the signature, address, and social security account number (if any) of each additional employee who concurs in the filing of the certificate. The list and any supplemental list shall be filed in such form and manner as may be prescribed by regulations made under this chapter.

(B) The certificate shall be in effect (for purposes of subsection (b)(8)(B) and for purposes of section 210(a)(8)(B) of the Social Security Act) for the period beginning with whichever of the following may be designated by the organization:

- (i) the first day of the calendar quarter in which the certificate is filed,

(ii) the first day of the calendar quarter succeeding such quarter, or

(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed.

(C) In the case of service performed by an employee whose name appears on a supplemental list filed after the first month following the calendar quarter in which the certificate is filed, the certificate shall be in effect (for purposes of subsection (b) (8) (B) and for purposes of section 210(a) (8) (B) of the Social Security Act) only with respect to service performed by such individual for the period beginning with the first day of the calendar quarter in which such supplemental list is filed.

(D) The period for which a certificate filed pursuant to this subsection or the corresponding subsection of prior law is effective may be terminated by the organization, effective at the end of a calendar quarter, upon giving 2 years' advance notice in writing, but only if, at the time of the receipt of such notice, the certificate has been in effect for a period of not less than 8 years. The notice of termination may be revoked by the organization by giving, prior to the close of the calendar quarter specified in the notice of termination, a written notice of such revocation. Notice of termination or revocation thereof shall be filed in such form and manner, and with such official, as may be prescribed by regulations made under this chapter.

(E) If an organization described in subparagraph (A) employs both individuals who are in positions covered by a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof and individuals who are not in such positions, the organization shall divide its employees into two separate groups. One group shall consist of all employees who are in positions covered by such a fund or system and (i) are members of such fund or system, or (ii) are not members of such fund or system but are eligible to become members thereof; and the other group shall consist of all remaining employees. An organization which has so divided its employees into two groups may file a certificate pursuant to subparagraph (A) with respect to the employees in either group, or may file a separate certificate pursuant to such subparagraph with respect to the employees in each group.

(F) An organization which filed a certificate under this subsection after 1955 but prior to the enactment of this subparagraph may file a request at any time before 1960 to have such certificate effective, with respect to the service of individuals who concurred in the filing of such certificate (initially or through the filing of a supplemental list) prior to enactment of this subparagraph and who concur in the filing of such new request, for the period beginning with the first day of any calendar quarter preceding the first calendar quarter for which it was effective and following the last calendar quarter of 1955. Such request shall be filed with such official and in such form and manner as may be prescribed by

regulations made under this chapter. If a request is filed pursuant to this subparagraph—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return or pay tax), the due date for the return and payment of the tax for any calendar quarter resulting from the filing of such request shall be the last day of the calendar month following the calendar quarter in which the request is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(G) If a certificate filed pursuant to this paragraph is effective for one or more calendar quarters prior to the quarter in which the certificate is filed, then—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return or pay tax), the due date for the return and payment of the tax for such prior calendar quarters resulting from the filing of such certificate shall be the last day of the calendar month following the calendar quarter in which the certificate is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(H) An organization which files a certificate under subparagraph (A) before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is so amended. If an organization amends its certificate pursuant to the preceding sentence, such amendment shall be effective with respect to the service of individuals who concurred in the filing of such certificate (initially or through the filing of a supplemental list) and who concur in the filing of such amendment. An amendment to a certificate filed pursuant to this subparagraph shall be filed with such official and in such form and manner as may be prescribed by regulations made under this chapter. If an amendment is filed pursuant to this subparagraph—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return or pay tax), the due date for the return and payment of the tax for any calendar quarter resulting from the filing of such an amendment shall be the last day of the calendar month following the calendar quarter in which the amendment is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of three years from such due date.

(2) **TERMINATION OF WAIVER PERIOD BY SECRETARY OR HIS DELEGATE.**—If the Secretary or his delegate finds that any organization which filed a certificate pursuant to this subsection or the corresponding subsection of prior law has failed to comply substantially with the requirements applicable with respect to the taxes imposed by

this chapter or the corresponding provisions of prior law or is no longer able to comply with the requirements applicable with respect to the taxes imposed by this chapter, the Secretary or his delegate shall give such organization not less than 60 days' advance notice in writing that the period covered by such certificate will terminate at the end of the calendar quarter specified in such notice. Such notice of termination may be revoked by the Secretary or his delegate by giving, prior to the close of the calendar quarter specified in the notice of termination, written notice of such revocation to the organization. No notice of termination or of revocation thereof shall be given under this paragraph to an organization without the prior concurrence of the Secretary of Health, Education, and Welfare.

(3) **NO RENEWAL OF WAIVER.**—In the event the period covered by a certificate filed pursuant to this subsection or the corresponding subsection of prior law is terminated by the organization, no certificate may again be filed by such organization pursuant to this subsection.

(1) **AGREEMENTS ENTERED INTO BY DOMESTIC CORPORATIONS WITH RESPECT TO FOREIGN SUBSIDIARIES.**—

(1) **AGREEMENTS ENTERED INTO BY DOMESTIC CORPORATIONS WITH SUBSIDIARIES.**—The Secretary or his delegate shall, at the request of any domestic corporation, enter into an agreement (in such form and manner as may be prescribed by the Secretary or his delegate) with any such corporation which desires to have the insurance system established by title II of the Social Security Act extended to service performed outside the United States in the employ of any one or more of its foreign subsidiaries (as defined in paragraph (8)) by all employees who are citizens of the United States, except that the agreement shall not be applicable to any service performed by, or remuneration paid to, an employee if such service or remuneration would be excluded from the term "employment" or "wages", as defined in this section, had the service been performed in the United States. Such agreement may be amended at any time so as to be made applicable, in the same manner and under the same conditions, with respect to any other foreign subsidiary of such domestic corporation. Such agreement shall be applicable with respect to citizens of the United States who, on or after the effective date of the agreement, are employees of and perform services outside the United States for any foreign subsidiary specified in the agreement. Such agreement shall provide—

(A) that the domestic corporation shall pay to the Secretary or his delegate, at such time or times as the Secretary or his delegate may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 (including amounts equivalent to the interest, additions, to the taxes, additional amounts, and penalties which would be applicable) with respect to the remuneration which would be wages if the services covered by the agreement constituted employment as defined in this section; and

(B) that the domestic corporation will comply with such regulations relating to payments and reports as the Secretary or his delegate may prescribe to carry out the purposes of this subsection.

(2) **EFFECTIVE PERIOD OF AGREEMENT.**—An agreement entered into pursuant to paragraph (1) shall be in effect for the period beginning

with the first day of the calendar quarter in which such agreement is entered into or the first day of the succeeding calendar quarter, as may be specified in the agreement, but in no case prior to January 1, 1955; except that in case such agreement is amended to include the services performed for any other subsidiary and such amendment is executed after the first month following the first calendar quarter for which the agreement is in effect, the agreement shall be in effect with respect to service performed for such other subsidiary only after the calendar quarter in which such amendment is executed.

(3) **TERMINATION OF PERIOD BY A DOMESTIC CORPORATION.**—The period for which an agreement entered into pursuant to paragraph (1) of this subsection is effective may be terminated with respect to any one or more of its foreign subsidiaries by the domestic corporation, effective at the end of a calendar quarter, upon giving two years' advance notice in writing, but only if, at the time of the receipt of such notice, the agreement has been in effect for a period of not less than eight years. The notice of termination may be revoked by the domestic corporation by giving, prior to the close of the calendar quarter specified in the notice of termination, a written notice of such revocation. Notice of termination or revocation thereof shall be filed in such form and manner as may be prescribed by regulations. Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign corporation shall terminate at the end of any calendar quarter in which the foreign corporation, at any time in such quarter, ceases to be a foreign subsidiary as defined in paragraph (8).

(4) **TERMINATION OF PERIOD BY SECRETARY.**—If the Secretary or his delegate finds that any domestic corporation which entered into an agreement pursuant to this subsection has failed to comply substantially with the terms of such agreement, the Secretary or his delegate shall give such domestic corporation not less than sixty days' advance notice in writing and the period covered by such agreement will terminate at the end of the calendar quarter specified in such notice. Such notice of termination may be revoked by the Secretary or his delegate by giving, prior to the close of the calendar quarter specified in the notice of termination, written notice of such revocation to the domestic corporation. No notice of termination or of revocation thereof shall be given under this paragraph to a domestic corporation without the prior concurrence of the Secretary of Health, Education, and Welfare.

(5) **NO RENEWAL OF AGREEMENT.**—If any agreement entered into pursuant to paragraph (1) of this subsection is terminated in its entirety (A) by a notice of termination filed by the domestic corporation pursuant to paragraph (3), or (B) by a notice of termination given by the Secretary or his delegate pursuant to paragraph (4), the domestic corporation may not again enter into an agreement pursuant to paragraph (1). If any such agreement is terminated with respect to any foreign subsidiary, such agreement may not thereafter be amended so as again to make it applicable with respect to such subsidiary.

(6) DEPOSITS IN TRUST FUNDS.—For purposes of section 201 of the Social Security Act, relating to appropriations to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, such remuneration—

(A) paid for services covered by an agreement entered into pursuant to paragraph (1) as would be wages if the services constituted employment, and

(B) as is reported to the Secretary or his delegate pursuant to the provisions of such agreement or of the regulations issued under this subsection, shall be considered wages subject to the taxes imposed by this chapter.

(7) OVERPAYMENTS AND UNDERPAYMENTS.—

(A) If more or less than the correct amount due under an agreement entered into pursuant to this subsection is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be required by regulations prescribed by the Secretary or his delegate.

(B) If an overpayment cannot be adjusted under subparagraph (A), the amount thereof shall be paid by the Secretary or his delegate, through the Fiscal Service of the Treasury Department, but only if a claim for such overpayment is filed with the Secretary or his delegate within two years from the time such overpayment was made.

(8) DEFINITION OF FOREIGN SUBSIDIARY.—For purposes of this subsection and section 210(a) of the Social Security Act, a foreign subsidiary of a domestic corporation is—

(A) a foreign corporation not less than 20 percent of the voting stock of which is owned by such domestic corporation; or

(B) a foreign corporation more than 50 percent of the voting stock of which is owned by the foreign corporation described in subparagraph (A).

(9) DOMESTIC CORPORATION AS SEPARATE ENTITY.—Each domestic corporation which enters into an agreement pursuant to paragraph (1) of this subsection shall, for purposes of this subsection and section 6413(c)(2)(C), relating to special refunds in the case of employees of certain foreign corporations, be considered an employer in its capacity as a party to such agreement separate and distinct from its identity as a person employing individuals on its own account.

(10) REGULATIONS.—Regulations of the Secretary or his delegate to carry out the purposes of this subsection shall be designed to make the requirements imposed on domestic corporations with respect to services covered by an agreement entered into pursuant to this subsection the same, so far as practicable, as those imposed upon employers pursuant to this title with respect to the taxes imposed by this chapter.

(m) SERVICE IN THE UNIFORMED SERVICES.—For purposes of this chapter—

(1) INCLUSION OF SERVICE.—The term “employment” shall, notwithstanding the provisions of subsection (b) of this section, include service performed after December 1956 by an individual as a

member of a uniformed service on active duty; but such terms shall not include any such service which is performed while on leave without pay.

(2) **ACTIVE DUTY.**—The term “active duty” means “active duty” as described in section 102 of the Servicemen’s and Veterans’ Survivor Benefits Act, except that it shall also include “active duty for training” as described in such section.

(3) **INACTIVE DUTY TRAINING.**—The term “inactive duty training” means “inactive duty training” as described in such section 102.

(n) **MEMBER OF A UNIFORMED SERVICE.**—For purposes of this chapter, the term “member of a uniformed service” means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component of a uniformed service as defined in section 102(3) of the Servicemen’s and Veterans’ Survivor Benefits Act), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers’ Training Corps, the Naval Reserve Officers’ Training Corps, or the Air Force Reserve Officers’ Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military or naval service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Universal Military Training and Service

Act, has been selected for active military or naval service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

(o) **CREW LEADER.**—For purposes of this chapter, the term “crew leader” means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. For purposes of this chapter and chapter 2, a crew leader shall, with respect to service performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

(p) **PEACE CORPS VOLUNTEER SERVICE.**—For purposes for this chapter, the term “employment” shall, notwithstanding the provisions of subsection (b) of this section, include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act.

(q) **TIPS INCLUDED FOR EMPLOYEE TAXES.**—For purposes of this chapter other than for purposes of the taxes imposed by section 3111, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received.

(r) **ELECTION OF COVERAGE BY RELIGIOUS ORDERS.**—

(1) **CERTIFICATE OF ELECTION BY ORDER.**—*A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of such order, may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) electing to have the insurance system established by title II of the Social Security Act extended to services performed by its members in the exercise of duties required by such order or such subdivision thereof. Such certificate of election shall provide that—*

(A) *such election of coverage by such order or subdivision shall be irrevocable;*

(B) *such election shall apply to all current and future members of such order, or in the case of a subdivision thereof to all current and future members of such order who belong to such subdivision;*

(C) *all services performed by a member of such an order or subdivision in the exercise of duties required by such order or subdivision shall be deemed to have been performed by such member as an employee of such order or subdivision; and*

(D) *the wages of each member, upon which such order or subdivision shall pay the taxes imposed by sections 3101 and 3111, will be determined as provided in subsection (i) (4).*

(2) **DEFINITION OF MEMBER.**—*For purposes of this subsection, a member of a religious order means any individual who is subject to a vow of poverty as a member of such order and who performs tasks usually required (and to the extent usually required) of an active member of such order and who is not considered retired because of old age or total disability.*

(3) **EFFECTIVE DATE FOR ELECTION.**—(A) *A certificate of election of coverage shall be in effect, for purposes of subsection (b)(8)(A) and for purposes of section 210(a)(8)(A) of the Social Security Act, for the period beginning with whichever of the following may be designated by the order or subdivision thereof:*

(i) *the first day of the calendar quarter in which the certificate is filed,*

(ii) *the first day of the calendar quarter succeeding such quarter, or*

(iii) *the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed.*

Whenever a date is designated under clause (iii), the election shall apply to services performed before the quarter in which the certificate is filed

only if the member performing such services was a member at the time such services were performed and is living on the first day of the quarter in which such certificate is filed.

(B) If a certificate of election filed pursuant to this subsection is effective for one or more calendar quarters prior to the quarter in which such certificate is filed, then—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for such prior calendar quarters resulting from the filing of such certificate shall be the last day of the calendar month following the calendar quarter in which the certificate is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(4) **COORDINATION WITH COVERAGE OF LAY EMPLOYEES.**—Notwithstanding the preceding provisions of this subsection, no certificate of election shall become effective with respect to an order or subdivision thereof, unless—

(A) if at the time the certificate of election is filed a certificate of waiver of exemption under subsection (k) is in effect with respect to such order or subdivision, such order or subdivision amends such certificate of waiver of exemption (in such form and manner as may be prescribed by regulations made under this chapter) to provide that it may not be revoked, or

(B) if at the time the certificate of election is filed a certificate of waiver of exemption under such subsection is not in effect with respect to such order or subdivision, such order or subdivision files such certificate of waiver of exemption under the provisions of such subsection except that such certificate of waiver of exemption cannot become effective at a later date than the certificate of election and such certificate of waiver of exemption must specify that such certificate of waiver of exemption may not be revoked. The certificate of waiver of exemption required under this subparagraph shall be filed notwithstanding the provisions of subsection (k)(3).

(5) **SERVICE PERFORMED UNDER CONTRACT BY PARTICIPANTS IN GUARANTEED EMPLOYMENT.**—For purposes of this chapter, the term “employment” shall, notwithstanding the provisions of subsection (b) of this section, include service performed by a participant in guaranteed employment provided by the Work Administration under title XX of the Social Security Act, but only if—

(1) such service is performed for or on behalf of an employer pursuant to a contract entered into between the Work Administration and such employer under section 2052(e) of such Act; and

(2) the remuneration paid by the Work Administration to such participant to compensate him for the performance of such service would have constituted wages (within the meaning of subsection (a)) if—

(A) such participant had performed such service as an employee of such employer; and

(B) such employer had paid such remuneration to such participant to compensate him for the performance of such service.

(6) **CERTAIN EMPLOYEES OF MEMBERS OF AFFILIATED GROUPS.**—For purposes of this chapter, an employee whose wages are paid by a corporation which is a member of an affiliated group, but who performs

services for one or more other members of the affiliated group, shall be treated as being in the employment only of the corporation which pays his wages. For purposes of the preceding sentence, the term "affiliated group" has the meaning assigned to it by section 1504(a), except that, for such purposes, any corporation shall be treated as an includible corporation.

SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of section 3121 (m) (1) are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121 (p) are applicable, *and including service, performed by a participant in guaranteed employment provided by the Work Administration, to which the provisions of section 3121 (s) are applicable*, the determination whether an individual has performed service which constitutes employment as defined in section 3121 (b), the determination of the amount of remuneration for such service which constitutes wages as defined in section 3121 (a), and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the \$10,800 limitation in section 3121 (a) (1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121 (i) (1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121 (m) (1) are applicable, shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary shall be deemed to be the head of such instrumentality.

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CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

- Sec. 3301. Rate of tax.
- Sec. 3302. Credits against tax.
- Sec. 3303. Conditions of additional credit allowance.
- Sec. 3304. Approval of State laws.
- Sec. 3305. Applicability of State law.
- Sec. 3306. Definitions.
- Sec. 3307. Deductions as constructive payments.
- Sec. 3308. Instrumentalities of the United States.
- Sec. 3309. State law coverage of certain services performed for non-profit organizations and for State hospitals and institutions of higher education.
- Sec. 3310. Judicial review.
- Sec. 3311. Short title.

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SEC. 3306. DEFINITIONS.

(a) **EMPLOYER.**—For purposes of this chapter, the term “employer” means, with respect to any calendar year, any person who—

(1) during any calendar quarter in the calendar year or the preceding calendar year paid wages of \$1,500 or more, or

(2) on each of some 20 days during the calendar year or during the preceding calendar year, each day being in a different calendar week, employed at least one individual in employment for some portion of the day.

(b) **WAGES.**—For purposes of this chapter, the term “wages” means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term shall not include—

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to \$4,200 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to \$4,200 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide

for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

- (A) retirement, or
- (B) sickness or accident disability, or
- (C) medical or hospitalization expenses in connection with sickness or accident disability, or
- (D) death;

(3) any payment made to an employee (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement;

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a), or

(C) under or to a bond purchase plan which, at the time of such payment, is a qualified bond purchase plan described in section 405(a);

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101 (or the corresponding section of prior law), or

(B) of any payment required from an employee under a State unemployment compensation law;

(7) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business;

(8) any payment (other than vacation or sick pay) made to an employee after the month in which he attains the age of 65, if he did not work for the employer in the period for which such payment is made;

(9) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217; or

(10) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, (ii) retirement for disability, or (iii) retirement after attaining an age specified in the

plan referred to in subparagraph (B) or in a pension plan of the employer, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated.

(c) **EMPLOYMENT.**—For purposes of this chapter, the term “employment” means any service performed prior to 1955, which was employment for purposes of subchapter C of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and (A) any service, of whatever nature, performed after 1954 by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, and (B) any service, of whatever nature, performed after 1971 outside the United States (except in a contiguous country with which the United States has an agreement relating to unemployment compensation or in the Virgin Islands) by a citizen of the United States as an employee of an American employer (as defined in subsection (j) (3)), except—

(1) agricultural labor (as defined in subsection (k));

(2) domestic service in a private home, local college club, or local chapter of a college fraternity or sorority;

(3) service not in the course of the employer's trade or business performed in any calendar quarter by an employee, unless the cash remuneration paid for such service is \$50 or more and such service is performed by an individual who is regularly employed by such employer to perform such service. For purposes of this paragraph, an individual shall be deemed to be regularly employed by an employer during a calendar quarter only if—

(A) on each of some 24 days during such quarter such individual performs for such employer for some portion of the day service not in the course of the employer's trade or business, or

(B) such individual was regularly employed (as determined under subparagraph (A)) by such employer in the performance of such service during the preceding calendar quarter;

(4) service performed on or in connection with a vessel or aircraft not an American vessel or American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;

(5) service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

(6) service performed in the employ of the United States Government or of an instrumentality of the United States which is—

- (A) wholly or partially owned by the United States, or
- (B) exempt from the tax imposed by section 3301 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;
- (7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions; and any service performed in the employ of any instrumentality of one or more States or political subdivisions to the extent that the instrumentality is, with respect to such service, immune under the Constitution of the United States from the tax imposed by section 3301;
- (8) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) which is exempt from income tax under section 501(a);
- (9) service performed by an individual as an employee or employee representative as defined in section 1 of the Railroad Unemployment Insurance Act (52 Stat. 1094, 1095; 45 U.S.C. 351);
- (10) (A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521, if the remuneration for such service is less than \$50, or
- (B) service performed in the employ of a school, college, or university, if such service is performed (i) by a student who is enrolled and is regularly attending classes at such school, college, or university, or (ii) by the spouse of such a student, if such spouse is advised, at the time such spouse commences to perform such service, that (I) the employment of such spouse to perform such service is provided under a program to provide financial assistance to such student by such school, college, or university, and (II) such employment will not be covered by any program of unemployment insurance, or
- (C) service performed by an individual under the age of 22 who is enrolled at a nonprofit or public educational institution which normally maintains a regular faculty and curriculum and normally has a regularly organized body of students in attendance at the place where its educational activities are carried on as a student in a full-time program, taken for credit at such institution, which combines academic instruction with work experience, if such service is an integral part of such program, and such institution has so certified to the employer, except that this subparagraph shall not apply to service performed in a program established for or on behalf of an employer or group of employers, or
- (D) service performed in the employ of a hospital, if such service is performed by a patient of such hospital;
- (11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);
- (12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law; and service performed as an intern in the employ of a hospital by an individual who has completed a 4 years' course in a medical school chartered or approved pursuant to State law;

(14) service performed by an individual for a person as an insurance agent or as an insurance solicitor, if all such service performed by such individual for such person is performed for remuneration solely by way of commission;

(15) (A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(16) service performed in the employ of an international organization;

(17) service performed by an individual in (or as an officer or member of the crew of a vessel while it is engaged in) the catching, taking, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacea, sponges, seaweeds, or other aquatic forms of animal and vegetable life (including service performed by any such individual as an ordinary incident to any such activity), except—

(A) service performed in connection with the catching or taking of salmon or halibut, for commercial purposes, and

(B) service performed on or in connection with a vessel of more than 10 net tons (determined in the manner provided for determining the register tonnage of merchant vessels under the laws of the United States); or

(18) service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a) (15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be.

(d) **INCLUDED AND EXCLUDED SERVICE.**—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection the term “pay period” means a period (of not more than 31 consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (c) (9).

(e) **STATE AGENCY.**—For purposes of this chapter, the term “State agency” means any State officer, board, or other authority, designated under a State law to administer the unemployment fund in such State.

(f) **UNEMPLOYMENT FUND.**—For purposes of this chapter, the term “unemployment fund” means a special fund, established under a State law and administered by a State agency, for the payment of compensation. Any sums standing to the account of the State agency in the Unemployment Trust Fund established by section 904 of the Social Security Act, as amended (49 Stat. 640; 52 Stat. 1104, 1105; 42 U.S.C. 1104), shall be deemed to be a part of the unemployment fund of the State and no sums paid out of the Unemployment Trust Fund to such State agency shall cease to be a part of the unemployment fund of the State until expended by such State agency. An unemployment fund shall be deemed to be maintained during a taxable year only if throughout such year, or such portion of the year as the unemployment fund was in existence, no part of the moneys of such fund was expended for any purpose other than the payment of compensation (exclusive of expenses of administration) and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305 (b); except that—

(1) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration; and

(2) the amounts specified by section 903 (c) (2) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices.

(g) **CONTRIBUTIONS.**—For purposes of this chapter, the term “contributions” means payments required by a State law to be made into an unemployment fund by any person on account of having individuals in his employ, to the extent that such payments are made by him without being deducted or deductible from the remuneration of individuals in his employ.

(h) **COMPENSATION.**—For purposes of this chapter, the term “compensation” means cash benefits payable to individuals with respect to their unemployment.

(i) **EMPLOYEE.**—For purposes of this chapter, the term “employee” has the meaning assigned to such term by section 3121 (d), except that subparagraphs (B) and (C) of paragraph (3) shall not apply.

(j) **STATE, UNITED STATES, AND CITIZEN.**—For purposes of this chapter—

(1) **STATE.**—The term “State” includes the District of Columbia and the Commonwealth of Puerto Rico.

(2) **UNITED STATES.**—The term “United States” when used in a geographical sense includes the States, the District of Columbia, and the Commonwealth of Puerto Rico.

(3) **AMERICAN EMPLOYER.**—The term “American employer” means a person who is—

(A) an individual who is a resident of the United States,

(B) a partnership, if two-thirds or more of the partners are residents of the United States,

(C) a trust, if all of the trustees are residents of the United States, or

(D) a corporation organized under the laws of the United States or of any State.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered for purposes of this section, as a citizen of the United States.

(k) **AGRICULTURAL LABOR.**—For purposes of this chapter, the term “agricultural labor” has the meaning assigned to such term by subsection (g) of section 3121, except that for purposes of this chapter subparagraph (B) of paragraph (4) of such subsection (g) shall be treated as reading:

“(B) in the employ of a group of operators of farms (or a cooperative organization of which such operators are members) in the performance of service described in subparagraph (A), but only if such operators produced more than one-half of the commodity with respect to which such service is performed;”

(1) [Repealed.]

(m) **AMERICAN VESSEL AND AIRCRAFT.**—For purposes of this chapter, the term “American vessel” means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term “American aircraft” means an aircraft registered under the laws of the United States.

(n) **VESSELS OPERATED BY GENERAL AGENTS OF UNITED STATES.**—Notwithstanding the provisions of subsection (c) (6), service performed on or after July 1, 1953, by officers and members of the crew of a vessel which would otherwise be included as employment under subsection (c) shall not be excluded by reason of the fact that it is performed on or in connection with an American vessel—

(1) owned by or bareboat chartered to the United States and

(2) whose business is conducted by a general agent of the Secretary of Commerce.

For purposes of this chapter, each such general agent shall be considered a legal entity in his capacity as such general agent, separate

and distinct from his identity as a person employing individuals on his own account, and the officers and members of the crew of such an American vessel whose business is conducted by a general agent of the Secretary of Commerce shall be deemed to be performing services for such general agent rather than the United States. Each such general agent who in his capacity as such is an employer within the meaning of subsection (a) shall be subject to all the requirements imposed upon an employer under this chapter with respect to service which constitutes employment by reason of this subsection.

(o) *CERTAIN EMPLOYEES OF MEMBERS OF AFFILIATED GROUPS.*—For purposes of this chapter, an employee whose wages are paid by a corporation which is a member of an affiliated group, but who performs services for one or more other members of the affiliated group, shall be treated as being in the employment only of the corporation which pays his wages. For purposes of the preceding sentence, the term “affiliated groups” has the meaning assigned to it by section 1504(a), except that, for such purposes, any corporation shall be treated as an includible corporation.

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Subtitle F—Procedure and Administration

- Chapter 61. Information and returns.
- Chapter 62. Time and place for paying tax.
- Chapter 63. Assessment.
- Chapter 64. Collection.
- Chapter 65. Abatements, credits, and refunds.
- Chapter 66. Limitations.
- Chapter 67. Interest.
- Chapter 68. Additions to the tax, additional amounts, and assessable penalties.
- Chapter 69. General provisions relating to stamps.
- Chapter 70. Jeopardy, bankruptcy and receiverships.
- Chapter 71. Transferees and fiduciaries.
- Chapter 72. Licensing and registration.
- Chapter 73. Bonds.
- Chapter 74. Closing agreements and compromises.
- Chapter 75. Crimes, other offenses, and forfeitures.
- Chapter 76. Judicial proceedings.
- Chapter 77. Miscellaneous provisions.
- Chapter 78. Discovery of liability and enforcement of title.
- Chapter 79. Definitions.
- Chapter 80. General rules.

CHAPTER 61—INFORMATION AND RETURNS

- SUBCHAPTER A. Returns and records.
- SUBCHAPTER B. Miscellaneous provisions.

Subchapter A—Returns and Records

- Part I. Records, statements, and special returns.
- Part II. Tax returns or statements.
- Part III. Information returns.
- Part IV. Signing and verifying of returns and other documents.
- Part V. Time for filing returns and other documents.
- Part VI. Extension of time for filing returns.
- Part VII. Place for filing returns or other documents.

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PART II—TAX RETURNS OR STATEMENTS

- Subpart A. General requirement.
 Subpart B. Income tax returns.
 Subpart C. Estate and gift tax returns.
 Subpart D. Miscellaneous provisions.

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Subpart B—Income Tax Returns

- Sec. 6012. Persons required to make returns of income.
 Sec. 6013. Joint returns of income tax by husband and wife.
 Sec. 6014. Income tax return—tax not computed by taxpayer.
 Sec. 6015. Declaration of estimated income tax by individuals.
 Sec. 6017. Self-employment tax returns.

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SEC. 6014. INCOME TAX RETURN—TAX NOT COMPUTED BY TAXPAYER.

(a) **ELECTION BY TAXPAYER.**—An individual entitled to elect to pay the tax imposed by section 3 whose gross income is less than \$10,000 and includes no income other than remuneration for services performed by him as an employee, dividends or interest, and whose gross income other than wages, as defined in section 3401 (a), does not exceed \$100, shall at his election not be required to show on the return the tax imposed by section 1. Such election shall be made by using the form prescribed for purposes of this section and shall constitute an election to pay the tax imposed by section 3. In such case the tax shall be computed by the Secretary or his delegate who shall mail to the taxpayer a notice stating the amount determined as payable. **[In determining the amount payable, the credit against such tax provided for by section 37 shall not be allowed.]**

(b) **REGULATIONS.**—The Secretary or his delegate shall prescribe regulations for carrying out this section, and such regulations may provide for the application of the rules of this section—

(1) to cases where the gross income includes items other than those enumerated by subsection (a),

(2) to cases where the gross income from sources other than wages on which the tax has been withheld at the source is more than \$100,

(3) to cases where the gross income is \$10,000 or more, *or*

[(4) to cases where the taxpayer is entitled to the credit provided by section 37 (relating to retirement income credit), or]

[(5)] (4) to cases where the taxpayer does not elect the standard deduction.

Such regulations shall provide for the application of this section in the case of husband and wife, including provisions determining when a joint return under this section may be permitted or required, whether the liability shall be joint and several, and whether one spouse may make return under this section and the other without regard to this section.

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PART III—INFORMATION RETURNS

Subpart A. Information concerning persons subject to special provisions.

Subpart B. Information concerning transactions with other persons.

Subpart C. Information regarding wages paid employees.

Subpart D. Information concerning private foundations.

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Subpart C—Information Regarding Wages Paid Employees

Sec. 6051. Receipt for employees.

Sec. 6052. Returns regarding payment of wages in the form of group-term life insurance.

Sec. 6053. Reporting of tips.

SEC. 6051. RECEIPTS FOR EMPLOYEES

(a) **REQUIREMENT.**—Every person required to deduct and withhold from an employee a tax under section 3101~~],~~ 3201~~],~~ or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, on the day on which the last payment of remuneration is made, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and his social security account number if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a), *and*
- (6) the total amount deducted and withheld as tax under section 3101~~],~~
- ~~[(7) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted, and~~
- ~~[(8) the total amount deducted as tax under section 3201.]~~

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a).

(b) **SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.**—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401 (a)).

(c) **ADDITIONAL REQUIREMENTS.**—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary or his delegate may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under sections 3101 and 3201 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) **STATEMENTS TO CONSTITUTE INFORMATION RETURNS.**—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary or his delegate shall, when required by such regulations, be filed with the Secretary or his delegate.

(e) **RAILROAD EMPLOYEES.**—

(1) **ADDITIONAL REQUIREMENT.**—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) **INFORMATION TO BE SUPPLIED TO EMPLOYEES.**—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

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CHAPTER 63—ASSESSMENT

SUBCHAPTER A. In general.

SUBCHAPTER B. Deficiency procedures in the case of income, estate, gift, and certain excise taxes.

Subchapter A—In General

Sec. 6201. Assessment authority.

Sec. 6202. Establishment by regulations of mode or time of assessment.

Sec. 6203. Method of assessment.

Sec. 6204. Supplemental assessments.

Sec. 6205. Special rules applicable to certain employment taxes.

Sec. 6206. Special rules applicable to excessive claims under sections 6420, 6421, 6424, and 6427.

Sec. 6207. Cross references.

SEC. 6201. ASSESSMENT AUTHORITY.

(a) **AUTHORITY OF SECRETARY OR DELEGATE.**—The Secretary or his delegate is authorized and required to make the inquiries, determinations, and assessments of all taxes (including interest, additional amounts, additions to the tax, and assessable penalties) imposed by this title, or accruing under any former internal revenue law, which have not been duly paid by stamp at the time and in the manner provided by law. Such authority shall extend to and include the following:

(1) **TAXES SHOWN ON RETURN.**—The Secretary or his delegate shall assess all taxes determined by the taxpayer or by the Secretary or his delegate as to which returns or lists are made under this title.

(2) **UNPAID TAXES PAYABLE BY STAMP.**—

(A) **OMITTED STAMPS.**—Whenever any article upon which a tax is required to be paid by means of a stamp is sold or removed for sale or use by the manufacturer thereof or whenever any transaction or act upon which a tax is required to be paid by means of a stamp occurs without the use of the proper stamp, it shall be the duty of the Secretary or his delegate, upon such information as he can obtain, to estimate the amount of tax which has been omitted to be paid and to make assessment therefor upon the person or persons the Secretary or his delegate determines to be liable for such tax.

(B) **CHECK OR MONEY ORDER NOT DULY PAID.**—In any case in which a check or money order received under authority of section 6311 as payment for stamps is not duly paid, the unpaid amount may be immediately assessed as if it were a tax imposed by this title, due at the time of such receipt, from the person who tendered such check or money order.

(3) **ERRONEOUS INCOME TAX PREPAYMENT CREDITS.**—If on any return or claim for refund of income taxes under subtitle A there is an overstatement of the credit for income tax withheld at the source, or of the amount paid as estimated income tax, the amount so overstated which is allowed against the tax shown on the return or which is allowed as a credit or refund may be assessed by the Secretary or his delegate in the same manner as in the case of a mathematical error appearing upon the return.

(4) **ERRONEOUS CREDIT UNDER SECTION 39 or 42.**—If on any return or claim for refund of income taxes under subtitle A there is an overstatement of the credit allowable by section 39 (relating to certain uses of gasoline, special fuels, and lubricating oil) or section 42 (relating to work bonus), the amount so overstated which is allowed against the tax shown on the return or which is allowed as a credit or refund may be assessed by the Secretary or his delegate in the same manner as in the case of a mathematical error appearing upon the return.

Subchapter B—Deficiency Procedures in the Case of Income, Estate, Gift, and Certain Excise Taxes

Sec. 6211. Definition of a deficiency.

Sec. 6212. Notice of deficiency.

Sec. 6213. Restrictions applicable to deficiencies; petition to Tax Court.

Sec. 6214. Determinations by Tax Court.

Sec. 6215. Assessment of deficiency found by Tax Court.

Sec. 6216. Cross references.

SEC. 6211. DEFINITION OF A DEFICIENCY.

(a) **IN GENERAL.**—For purposes of this title in the case of income, estate, gift, and excise taxes, imposed by subtitles A and B, and chapter 42, the term “deficiency” means the amount by which the tax imposed by subtitle A or B or chapter 42 exceeds the excess of—

(1) the sum of

(A) the amount shown as the tax by the taxpayer upon his return, if a return was made by the taxpayer and an amount was shown as the tax by the taxpayer thereon, plus

(B) the amounts previously assessed (or collected without assessment) as a deficiency, over—

(2) the amount of rebates, as defined in subsection (b) (2), made.

(b) **RULES FOR APPLICATION OF SUBSECTION (a).**—For purposes of this section—

(1) The tax imposed by subtitle A and the tax shown on the return shall both be determined without regard to payments on account of estimated tax, without regard to the credit under section 31, and without regard to so much of the credit under section 32 as exceeds 2 percent of the interest on obligations described in section 1451.

(2) The term “rebate” means so much of an abatement, credit, refund, or other repayment, as was made on the ground that the tax imposed by subtitle A or B or chapter 42 was less than the excess of the amount specified in subsection (a) (1) over the rebates previously made.

(3) The computation by the Secretary or his delegate, pursuant to section 6014, of the tax imposed by chapter 1 shall be considered as having been made by the taxpayer and the tax so computed considered as shown by the taxpayer upon his return.

(4) The tax imposed by subtitle A and the tax shown on the return shall both be determined without regard to the [credit] credits under section 39 and 42, unless, without regard to such [credit]

credits, the tax imposed by subtitle A exceeds the excess of the amount specified in subsection (a) (1) over the amount specified in subsection (a) (2).

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SEC. 6213. RESTRICTIONS APPLICABLE TO DEFICIENCIES; PETITION TO TAX COURT.

(a) **TIME FOR FILING PETITION AND RESTRICTION ON ASSESSMENT.**—Within 90 days, or 150 days if the notice is addressed to a person outside the States of the Union and the District of Columbia, after the notice of deficiency authorized in section 6212 is mailed (not counting Saturday, Sunday, or a legal holiday in the District of Columbia as the last day), the taxpayer may file a petition with the Tax Court for a redetermination of the deficiency. Except as otherwise provided in section 6861 no assessment of a deficiency in respect of any tax imposed by subtitle A or B or chapter 42 and no levy or proceeding in court for its collection shall be made, begun, or prosecuted until such notice has been mailed to the taxpayer, nor until the expiration of such 90-day or 150-day period, as the case may be, nor, if a petition has been filed with the Tax Court, until the decision of the Tax Court has become final. Notwithstanding the provisions of section 7421(a), the making of such assessment or the beginning of such proceeding or levy during the time such prohibition is in force may be enjoined by a proceeding in the proper court.

(b) **EXCEPTIONS TO RESTRICTIONS ON ASSESSMENT.**—

(1) **MATHEMATICAL ERRORS.**—If the taxpayer is notified that, on account of a mathematical error appearing upon the return, an amount of tax in excess of that shown upon the return is due, and that an assessment of the tax has been or will be made on the basis of what would have been the correct amount of tax but for the mathematical error, such notice shall not be considered as a notice of deficiency for the purposes of subsection (a) (prohibiting assessment and collection until notice of the deficiency has been mailed), or of section 6212(c) (1) (restricting further deficiency letters), or section 6512(a) (prohibiting credits or refunds after petition to the Tax Court), and the taxpayer shall have no right to file a petition with the Tax Court based on such notice, nor shall such assessment or collection be prohibited by the provisions of subsection (a) of this section.

(2) **ASSESSMENTS ARISING OUT OF TENTATIVE CARRYBACK ADJUSTMENTS.**—If the Secretary or his delegate determines that the amount applied, credited, or refunded under section 6411 is in excess of the overassessment attributable to the carryback with respect to which such amount was applied, credited, or refunded, he may assess the amount of the excess as a deficiency as if it were due to a mathematical error appearing on the return.

(3) **ASSESSMENT OF AMOUNT PAID.**—Any amount paid as a tax or in respect of a tax may be assessed upon the receipt of such payment notwithstanding the provisions of subsection (a). In any case where such amount is paid after the mailing of a notice of deficiency under section 6212, such payment shall not deprive the Tax Court of juris-

diction over such deficiency determined under section 6211 without regard to such assessment.

(c) **FAILURE TO FILE PETITION.**—If the taxpayer does not file a petition with the Tax Court within the time prescribed in subsection (a), the deficiency, notice of which has been mailed to the taxpayer, shall be assessed, and shall be paid upon notice and demand from the Secretary or his delegate.

(d) **WAIVER OF RESTRICTIONS.**—The taxpayer shall at any time (whether or not a notice of deficiency has been issued) have the right, by a signed notice in writing filed with the Secretary or his delegate, to waive the restrictions provided in subsection (a) on the assessment and collection of the whole or any part of the deficiency.

(e) **SUSPENSION OF FILING PERIOD FOR CERTAIN CHAPTER 42 TAXES.**—The running of the time prescribed by subsection (a) for filing a petition in the Tax Court with respect to the taxes imposed by section 4941 (relating to taxes on self-dealing), 4942 (relating to taxes on failure to distribute income), 4943 (relating to taxes on excess business holdings), 4944 (relating to investments which jeopardize charitable purpose), or 4945 (relating to taxes on taxable expenditures) shall be suspended for any period during which the Secretary or his delegate has extended the time allowed for making corrections under section 4941 (e) (4), 4942 (j) (2), 4943 (d) (3), 4944 (e) (3), or 4945 (h) (2).

(f) **CROSS REFERENCES.**—

(1) for assessment as if a mathematical error on the return, in the case of erroneous claims for income tax prepayment credits, see section 6201 (a) (3).

(2) for assessments without regard to restrictions imposed by this section in the case of—

(A) recovery of foreign income taxes, see section 905 (c).

(B) recovery of foreign estate tax, see section 2016.

(3) for assessment as if a mathematical error on the return, in the case of erroneous claims for credits under section 39 *or* 42, see section 6201 (a) (4).

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CHAPTER 64—COLLECTION

SUBCHAPTER A. General provisions.

SUBCHAPTER B. Receipt of payment.

SUBCHAPTER C. Lien for taxes.

SUBCHAPTER D. Seizure of property for collection of taxes.

Subchapter A—General Provisions

Sec. 6301. Collection authority.

Sec. 6302. Mode or time of collection.

Sec. 6303. Notice and demand for tax.

Sec. 6304. Collection under the Tariff Act.

Sec. 6305. *Collection of certain liability to the United States.*

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SEC. 6305. COLLECTION OF CERTAIN LIABILITY TO THE UNITED STATES.

Upon receiving a certification from the Attorney General under section 452(b)(1) of the Social Security Act with respect to any individual, the Secretary or his delegate shall assess and collect the

amount certified by the Attorney General in the same manner, with the same powers, and (except as provided in this section) subject to the same limitations as if such amount were a tax imposed by subtitle C the collection of which would be jeopardized by delay, except that—

(1) no interest or penalties shall be assessed or collected, and

(2) for such purposes, paragraphs (4), (6), and (8) of section 6334(a) (relating to property exempt from levy) shall not apply.

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Subchapter D—Seizure of Property for Collection of Taxes

- Sec. 6331. Levy and distraint.
- Sec. 6332. Surrender of property subject to levy.
- Sec. 6333. Production of books.
- Sec. 6334. Property exempt from levy.
- Sec. 6335. Sale of seized property.
- Sec. 6336. Sale of perishable goods.
- Sec. 6337. Redemption of property.
- Sec. 6338. Certificate of sale; deed of real property
- Sec. 6339. Legal effect of certificate of sale of personal property and deed of real property.
- Sec. 6340. Records of sale.
- Sec. 6341. Expense of levy and sale.
- Sec. 6342. Application of proceeds of levy.
- Sec. 6343. Authority to release levy and return property.
- Sec. 6344. Cross references.

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SEC. 6334. PROPERTY EXEMPT FROM LEVY.

(a) ENUMERATION.—There shall be exempt from levy—

(1) WEARING APPAREL AND SCHOOL BOOKS.—Such items of wearing apparel and such school books as are necessary for the taxpayer or for members of his family;

(2) FUEL, PROVISIONS, FURNITURE, AND PERSONAL EFFECTS.—If the taxpayer is the head of a family, so much of the fuel, provisions, furniture, and personal effects in his household, and of the arms for personal use, livestock, and poultry of the taxpayer, as does not exceed \$500 in value;

(3) BOOKS AND TOOLS OF A TRADE, BUSINESS, OR PROFESSION.—So many of the books and tools necessary for the trade, business, or profession of the taxpayer as do not exceed in the aggregate \$250 in value.

(4) UNEMPLOYMENT BENEFITS.—Any amount payable to an individual with respect to his unemployment (including any portion thereof payable with respect to dependents) under an unemployment compensation law of the United States, of any State, or of the District of Columbia or of the Commonwealth of Puerto Rico.

(5) UNDELIVERED MAIL.—Mail, addressed to any person, which has not been delivered to the addressee.

(6) CERTAIN ANNUITY AND PENSION PAYMENTS.—Annuity or pension payments under the Railroad Retirement Act, benefits under the Railroad Unemployment Insurance Act, special pension payment received by a person whose name has been entered on the Army, Navy, Air Force, and Coast Guard Medal of Honor roll (38 U.S.C.

562), and annuities based on retired or retainer pay under chapter 73 of title 10 of the United States Code.

(7) **WORKMEN'S COMPENSATION.**—Any amount payable to an individual as workmen's compensation (including any portion thereof payable with respect to dependents) under a workmen's compensation law of the United States, any State, the District of Columbia or the Commonwealth of Puerto Rico.

(8) **SALARY, WAGES, OF OTHER INCOME.**—If the taxpayer is required by judgment of a court of competent jurisdiction, entered prior to the date of levy, to contribute to the support of his minor children, so much of his salary, wages, or other income as is necessary to comply with such judgment.

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CHAPTER 65—ABATEMENTS, CREDITS, AND REFUNDS

SUBCHAPTER A. Procedure in general.

SUBCHAPTER B. Rules of special application.

Subchapter A—Procedure in General

Sec. 6401. Amounts treated as overpayments.

Sec. 6402. Authority to make credits or refunds.

Sec. 6403. Overpayment of installment.

Sec. 6404. Abatements.

Sec. 6405. Reports of refunds and credits.

Sec. 6406. Prohibition of administrative review of decisions.

Sec. 6407. Date of allowance of refund or credit.

SEC. 6401. AMOUNTS TREATED AS OVERPAYMENTS.

(a) **ASSESSMENT AND COLLECTION AFTER LIMITATION PERIOD.**—The term "overpayment" includes that part of the amount of the payment of any internal revenue tax which is assessed or collected after the expiration of the period of limitation properly applicable thereto.

(b) **EXCESSIVE CREDITS.**—If the amount allowable as credits under sections 31 (relating to tax withheld on wages), 39 (relating to certain uses of gasoline, special fuels, and lubricating oil) 42 (relating to work bonus), and 667(b) (relating to taxes paid by certain trusts) exceeds the tax imposed by subtitle A (reduced by the credits allowable under subpart A of part IV of subchapter A of chapter 1, other than the credits allowable under sections 31 and 39), the amount of such excess shall be considered an overpayment.

(c) **RULE WHERE NO TAX LIABILITY.**—An amount paid as tax shall not be considered not to constitute an overpayment solely by reason of the fact that there was no tax liability in respect of which such amount was paid.

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Subchapter B—Rules of Special Application

- Sec. 6411. Tentative carryback adjustments.
- Sec. 6412. Floor stocks refunds.
- Sec. 6413. Special rules applicable to certain employment taxes.
- Sec. 6414. Income tax withheld.
- Sec. 6415. Credits or refunds to persons who collected certain taxes.
- Sec. 6416. Certain taxes on sales and services.
- Sec. 6417. Coconut and palm oil.
- Sec. 6418. Sugar.
- Sec. 6419. Excise tax on wagering.
- Sec. 6420. Gasoline used on farms.
- Sec. 6421. Gasoline used for certain nonhighway purposes or by local transit systems.
- Sec. 6422. Cross references.
- Sec. 6423. Conditions to allowance in the case of alcohol and tobacco taxes.
- Sec. 6424. Lubricating oil not used in highway motor vehicles.
- Sec. 6425. Adjustment of overpayment of estimated income tax by corporation.
- Sec. 6426. Refund of aircraft use tax where plane transports for hire in foreign air commerce.
- Sec. 6427. Fuels not used for taxable purposes.

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SEC. 6413. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.**(a) ADJUSTMENT OF TAX.—**

(1) **GENERAL RULE.**—If more than the correct amount of tax imposed by section 3101, 3111, 3201, 3221, or 3402 is paid with respect to any payment of remuneration, proper adjustments, with respect to both the tax and the amount to be deducted, shall be made, without interest, in such manner and at such times as the Secretary or his delegate may by regulations prescribe.

(2) **UNITED STATES AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received from the United States or a wholly owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall be deemed a separate employer.

(3) **GUAM OR AMERICAN SAMOA AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer.

(4) **DISTRICT OF COLUMBIA AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125 shall be deemed a separate employer.

(b) OVERPAYMENT OF CERTAIN EMPLOYMENT TAXES.—If more than

the correct amount of tax imposed by sections 3101, 3111, 3201, 3221, or 3402 is paid or deducted with respect to any payment of remuneration and the overpayment cannot be adjusted under subsection (a) of this section, the amount of the overpayment shall be refunded in such manner and at such times (subject to the statute of limitations properly applicable thereto) as the Secretary or his delegate may by regulations prescribe.

(c) SPECIAL REFUNDS.—

(1) IN GENERAL.—If by reason of an employee receiving wages from more than one employer during a calendar year after the calendar year 1950 and prior to the calendar year 1955, the wages received by him during such year exceed \$3,600, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 1400 of the Internal Revenue Code of 1939 and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to the first \$3,600 of such wages received; or if by reason of an employee receiving wages from more than one employer (A) during any calendar year after the calendar year 1954 and prior to the calendar year 1959, the wages received by him during such year exceed \$4,200, or (B) during any calendar year after the calendar year 1958 and prior to the calendar year 1966, the wages received by him during such year exceed \$4,800, or (C) during any calendar year after the calendar year 1965 and prior to the calendar year 1968, the wages received by him during such year exceed \$6,600, or (D) during any calendar year after the calendar year 1967 and prior to the calendar year 1972, the wages received by him during such year exceed \$7,800, or (E) during any calendar year after the calendar year 1971 and prior to the calendar year 1973, the wages received by him during such year exceed \$9,000 or (F) during any calendar year after the calendar year 1972 and prior to the calendar year 1974, the wages received by him during such year exceed \$10,800, or (i) during any calendar year after the calendar year 1973 and prior to the calendar year 1975, the wages received by him during such year exceed \$12,000, or (H) during any calendar year after 1974, the wages received by him during such year exceed the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year; and the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101 and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to the first \$4,200 of such wages received in such calendar year after 1954 and before 1959, or which exceeds the tax with respect to the first \$4,800 of such wages received in such calendar year after 1958 and before 1966, or which exceeds the tax with respect to the first \$6,600 of such wages received in such calendar year after 1965 and before 1968, or which exceeds the tax with respect to the first \$7,800 of such wages received in such calendar year after 1967 and before 1972, or which exceeds the tax with respect

to the first \$9,000 of such wages received in such calendar year after 1971 and before 1973, or which exceeds the tax with respect to the first \$10,800 of such wages received in such calendar year after 1972 and before 1974, or which exceeds the tax with respect to the first \$12,000 of such wages received in such calendar year after 1973 and before 1975, or which exceeds the tax with respect to an amount of such wages received in such calendar year after 1974 equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year.

(2) **APPLICABILITY IN CASE OF FEDERAL AND STATE EMPLOYEES, EMPLOYEES OF CERTAIN FOREIGN CORPORATIONS, AND GOVERNMENTAL EMPLOYEES IN GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.—**

(A) **FEDERAL EMPLOYEES.—**In the case of remuneration received from the United States or a wholly owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall, for purposes of this subsection, be deemed a separate employer, and the term "wages" includes for purposes of this subsection the amount, not to exceed \$3,600 for the calendar year 1951, 1952, 1953, or 1954, \$4,200 for the calendar year 1955, 1956, 1957, or 1958, \$4,800 for the calendar year 1959, 1960, 1961, 1962, 1963, 1964, or 1965, \$6,600 for the calendar year 1966 or 1967, \$7,800 for the calendar year 1968, 1969, 1970, or 1971, or \$9,000 for the calendar year 1972, \$10,800 for the calendar year 1973, \$12,000 for the calendar year 1974, or an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) for any calendar year after 1974 with respect to which such contribution and benefit base is effective, determined by each such head or agent as constituting wages paid to an employee.

(B) **STATE EMPLOYEES.—**For purposes of this subsection, in the case of remuneration received during any calendar year, the term "wages" includes such remuneration for services covered by an agreement made pursuant to section 218 of the Social Security Act as would be wages if such services constituted employment; the term "employer" includes a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing; the term "tax" or "tax imposed by section 3101" includes, in the case of services covered by an agreement made pursuant to section 218 of the Social Security Act, an amount equivalent to the tax which would be imposed by section 3101, if such services constituted employment as defined in section 3121; and the provisions of this subsection shall apply whether or not any amount deducted from the employee's remuneration as a result of an agreement made pursuant to section 218 of the Social Security Act has been paid to the Secretary.

(C) **EMPLOYEES OF CERTAIN FOREIGN CORPORATIONS.—**For purposes of paragraph (1) of this subsection, the term "wages" includes such remuneration for services covered by an agreement made pursuant to section 3121(1) as would be wages if such services constituted employment; the term "employer" includes any

domestic corporation which has entered into an agreement pursuant to section 3121(1); the term "tax" or "tax imposed by section 3101," includes, in the case of services covered by an agreement entered into pursuant to section 3121(1), an amount equivalent to the tax which would be imposed by section 3101, if such services constituted employment as defined in section 3121; and the provisions of paragraph (1) of this subsection shall apply whether or not any amount deducted from the employee's remuneration as a result of the agreement entered into pursuant to section 3121(1) has been paid to the Secretary or his delegate.

(D) **GOVERNMENTAL EMPLOYEES IN GUAM.**—In the case of remuneration received from the Government of Guam or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of Guam and each agent designated by him who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer.

(E) **GOVERNMENTAL EMPLOYEES IN AMERICAN SAMOA.**—In the case of remuneration received from the Government of American Samoa or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of American Samoa and each agent designated by him who makes a return pursuant to section 3125(b) shall, for purposes of this subsection, be deemed a separate employer.

(F) **GOVERNMENTAL EMPLOYEES IN THE DISTRICT OF COLUMBIA.**—In the case of remuneration received from the District of Columbia or any instrumentality wholly owned thereby, during any calendar year, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125(c), shall, for purposes of this subsection, be deemed a separate employer.

(3) **APPLICABILITY WITH RESPECT TO COMPENSATION OF EMPLOYEES SUBJECT TO THE RAILROAD RETIREMENT TAX ACT.**—In the case of any individual who, during any calendar year after 1967, receives wages from one or more employers and also receives compensation which is subject to the tax imposed by section 3201 or 3211, such compensation shall, solely for purposes of applying paragraph (1) with respect to the tax imposed by section 3101(b), be treated as wages received from an employer with respect to which the tax imposed by section 3101(b) was deducted.

(d) **REFUND OR CREDIT OF FEDERAL UNEMPLOYMENT TAX.**—Any credit allowable under section 3302, to the extent not previously allowed, shall be considered an overpayment, but no interest shall be allowed or paid with respect to such overpayment.

(e) *SPECIAL REFUNDS OF SOCIAL SECURITY TAX TO MEMBERS OF CERTAIN RELIGIOUS FAITHS.*—

(1) *IN GENERAL.*—An employee who receives wages with respect to which the tax imposed by section 3101 is deducted during a calendar year for which an authorization granted under this subsection applies shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of the amount of tax so deducted.

(2) *AUTHORIZATION FOR CREDIT OR REFUND.*—Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this subsection) for an authorization for credit or refund of the tax imposed by section 3101 if he is a member of a recognized religious sect or division thereof described in section 1402(h)(1) and is an adherent of established tenets or teachings of such sect or division described in such section. Such authorization may be granted only if—

(A) the application contains or is accompanied by evidence described in section 1402(h)(1)(A) and a waiver described in section 1402(h)(1)(B), and

(B) the Secretary of Health, Education, and Welfare makes the findings described in section 1402(h)(1)(C), (D), and (E).
An authorization may not be granted to any individual if any benefit or other payment referred to in section 1402(h)(1)(B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of filing of such waiver.

(3) *EFFECTIVE PERIOD OF AUTHORIZATION.*—An authorization granted to any individual under this subsection shall apply with respect to wages paid to such individual during the period—

(A) commencing with the first day of the first calendar year after 1972 throughout which such individual meets the requirements specified in paragraph (2) and in which such individual files application for such authorization (except that if such application is filed on or before the date prescribed by law, including any extension thereof, for filing an income tax return for such individual's taxable year, such application may be treated as having been filed in the calendar year in which such taxable year begins), and

(B) ending with the first day of the calendar year in which (i) such individual ceases to meet the requirements of the first sentence of paragraph (2), or (ii) the sect or division thereof of which such individual is a member is found by the Secretary of Health, Education, and Welfare to have ceased to meet the requirements of subparagraph (B) of paragraph (2).

(4) *APPLICATION BY FIDUCIARIES OR SURVIVORS.*—If an individual who has received wages with respect to which the tax imposed by section 3101 has been deducted during a calendar year dies without having filed an application under paragraph (2) an application may be filed with respect to such individual by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act).

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Subtitle I—Work Bonus Program

CHAPTER 97. Work bonus program

CHAPTER 97.—WORK BONUS PROGRAM

Sec. 10001. Payment.

Sec. 10002. Recovery of overpayments; penalties.

Sec. 10003. Cooperation of other Government agencies.

Sec. 10004. Applications; regulations.

Sec. 10005. Definition of eligible individual.

Sec. 10006. Appropriation of funds for payments.

SEC. 10001. PAYMENT.

(a) *IN GENERAL.*—Except as provided in subsection (d), the Secretary or his delegate shall pay to each eligible individual, upon application therefor made after the close of a calendar year, an annual payment for that calendar year in an amount determined under subsection (b).

(b) *DETERMINATION OF AMOUNT.*—

(1) *IN GENERAL.*—The amount of the payment to which an eligible individual is entitled under this chapter for any calendar year is an amount equal to 10 percent of not more than \$4,000 of the wages or compensation paid to him, or to him and his spouse, if he is married (as determined under section 143)—

(A) with respect to which taxes were deducted and withheld under section 3102 (relating to deduction of tax from wages under the Federal Insurance Contributions Act) or section 3202 (relating to deduction of tax from compensation under the Railroad Retirement Act); or

(B) by the Work Administration for services performed by a participant in guaranteed employment and with respect to which the Work Administration certifies to the Secretary under section 2052(e)(4) of the Social Security Act was paid for services performed on behalf of an employer under a contract entered into with the Work Administration under section 2052(e) of such Act.

(2) *LIMITATION.*—The amount of the payment to which an eligible individual is entitled for any calendar year under paragraph (1) shall be reduced by one-fourth of the amount by which his income, or, if he is married (as determined under section 143), the total of his income and his spouse's income, for the calendar year exceeds \$4,000. For purposes of this paragraph, the term "income" means all income from whatever source derived, other than payments provided by this chapter, determined without regard to subtitle A (relating to income taxes).

(c) *ADVANCE PAYMENTS.*—

(1) *IN GENERAL.*—Upon application therefor made after the close of any of the first three quarters of any calendar year, the Secretary or his delegate shall pay to an eligible individual an advance payment on account of the annual payment to which he reasonably expects to be entitled under subsection (a) for that year. The amount of any advance payment to which an eligible individual is entitled at the close of any calendar quarter shall be equal to—

(A) the annual payment to which the eligible individual would be entitled with respect to the wages and compensation described in subsection (b)(1) received by him on or before the close of the most

recent quarter for which application is made, taking into account the wages, compensation, and other income received and reasonably expected to be received during the calendar year, reduced by

(B) the amount of advance payments made to him, or for which he made application, for any prior quarters of the calendar year.

(2) **MINIMUM ADVANCE PAYMENT.**—No advance payment shall be made under this subsection for any amount less than \$30.

(3) **DETERMINATION OF STATUS.**—For purposes of this subsection, the determination of whether an eligible individual is married shall be made as of the close of the calendar quarter or quarters for which an application for payment has been filed by that individual.

(4) **ANNUAL STATEMENT.**—Any individual who receives an advance payment under this subsection for any calendar year shall file, after the close of that year, a statement with the Secretary or his delegate setting forth the amounts he has received as advance payments under this subsection during that year, the amount of income he and his spouse, if any, have received during that year, and such other information as the Secretary or his delegate may require and in such form and at such time as he may require.

(d) **CREDIT IN LIEU OF PAYMENT.**—An eligible individual may elect for any taxable year to take the amount of any payment to which he is entitled under this chapter as a credit against tax under section 42. The election shall be filed at such time and in such form as the Secretary or his delegate may prescribe.

SEC. 10002. RECOVERY OF OVERPAYMENTS; PENALTIES.

(a) **RECOVERY OF OVERPAYMENTS.**—If the Secretary or his delegate determines that any part of any amount paid to an individual for any year under this chapter was in excess of the amount to which that individual was entitled under this chapter for that year, the Secretary or his delegate shall notify that individual of the excess payment and may—

(1) withhold, from any amounts which that individual is entitled to receive under this chapter in any subsequent year, amounts totaling not more than the amount of that excess;

(2) treat the amount of that excess as if it were a deficiency under subchapter B of chapter 63 of subtitle F and utilize the procedures available to him under that subtitle to collect that amount;

(3) enter into an agreement with that individual for the repayment of that amount; or

(4) take such other action as may be necessary to recover that amount.

(b) **PENALTIES.**—Each application form and any other document required to be filed under this chapter shall contain a written declaration that it is made under penalty of perjury. The provisions of chapter 75 (relating to crimes, other offenses, and forfeitures) shall apply to such forms and documents.

SEC. 10003. COOPERATION OF OTHER GOVERNMENT AGENCIES.

The Secretary or his delegate is authorized to obtain from any agency or department of the United States Government or of any State or political subdivision thereof such information with respect to any individual applying for or receiving benefits under this chapter, or any individual whose income is taken into consideration in determining benefits payable to an

eligible individual under this chapter, as may be necessary for the proper administration of this chapter. Each agency and department of the United States Government is authorized and directed to furnish to the Secretary or his delegate such information upon request.

SEC. 10004. APPLICATIONS; REGULATIONS.

(a) *IN GENERAL.*—*The Secretary or his delegate shall develop simple and expedient application forms and procedures for use by eligible individuals who wish to obtain the benefits of this chapter, arrange for distributing such forms and making them easily available to eligible individuals, and prescribe such regulations as may be necessary to carry out the provisions of this chapter.*

(b) *TIME FOR FILING APPLICATIONS FOR PAYMENT.*—*No annual payment may be made to an eligible individual for a calendar year unless the application for that payment is filed on or before the last day of the calendar quarter following the close of that year. No advance payment may be made to an eligible individual for any calendar quarter or quarters unless the application for that payment is filed on or before the last day of the calendar quarter following the close of the quarter or quarters for which application is filed. For purposes of section 42, failure to file an application for an annual payment within the time prescribed by this subsection shall not affect an eligible individual's entitlement to such payment.*

SEC. 10005. DEFINITION OF ELIGIBLE INDIVIDUAL.

For the purpose of this chapter, "eligible individual" means an individual—

- (1) *who is physically present in the United States;*
- (2) *whose wages are subject to tax under chapter 21 or 22 (relating to the Federal Insurance Contributions Act and the Railroad Retirement Tax Act, respectively) or who receives compensation from the Work Administration for services performed in guaranteed employment on behalf of an employer under a contract entered into with the Work Administration under section 2052(e) of the Social Security Act; and*
- (3) *who maintains a household which includes a child of that individual with respect to whom he is entitled to a deduction under section 151(e)(1)(B).*

SEC. 10006. APPROPRIATION OF FUNDS FOR PAYMENTS.

There is hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, for each fiscal year such sums as may be necessary to enable the Secretary or his delegate to make payments under this chapter.

XV. ADDITIONAL VIEWS OF MR. HARTKE

(1227)

XV. ADDITIONAL VIEWS OF SENATOR VANCE HARTKE

For the past 37 years, older Americans have benefited from a Government-supported retirement system. As the ranks of the retired increase, the deficiencies of that system have become manifest. Unfortunately, the Senate Finance Committee version of H.R. 1 does little to provide the type of sweeping reform which is needed by the Nation's retired and disabled workers.

Nine out of every ten people now in paid employment are covered or eligible for coverage under the social security program. More than 90 percent of all older citizens are now eligible for benefits. For millions of Americans, social security is the basis of protection against loss of income due to retirement, disability, or death of the family breadwinner.

During the past 13 years, I have introduced a series of proposals designed to provide the type of social security reform which would guarantee that no older American need live in poverty. I see no reason why a person should be forced to undergo a radical reduction in his standard of living simply because he retires from the active working force. A wage-earner's 65th birthday should be an occasion for joy and celebration, not one for despair and desperation.

The Senate committee approved several changes in the retirement and health benefits programs which are long overdue. Two are of special importance.

BLIND DISABILITY BENEFITS

The proposal adopted by the Senate Finance Committee is substantially similar to a bill which I have introduced over the past several years. That proposal would:

1. Reduce the number of quarters a blind person must be employed in social security-covered work to qualify for disability benefit payments from 20 of the last 40 quarters to 6 at anytime.
2. The "earnings" test in disability insurance would be entirely eliminated for blind persons applying for or receiving disability insurance payments.

Under existing law, any appreciable earnings disqualifies disabled persons from receiving or continuing to receive disability insurance payments.

This proposal recognizes that a person who tries to function sightless in our sight-structured world, functions at a financial disadvantage.

By allowing a blind person to draw disability insurance payments so long as he remains blind and irrespective of his earnings, this proposal would provide him a regular source of funds to pay for his "sight," and thus helps to reduce the economic disadvantages of blindness.

PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

Prescription drugs represent the largest single personal health expenditure the aged are now required to meet out of their own resources. A Department Task Force on Prescription Drugs, a Special Committee of non-governmental drug experts, and the 1971 Advisory Council on Social Security all recommended that prescription drugs be covered under Medicare. Drug coverage should provide protection for those who need it most—that is, to those who have recurring costs because of chronic ailment. The economic problem of the aged in relation to drug costs is not the occasional acute illness but the problem of a continuing drain of \$10, \$15 and \$20 a month for these maintenance drugs.

The approach which I offered as part of S. 906 and S. 2513 is substantially similar to the approach adopted by the Senate Finance Committee. It provides coverage for those drugs necessary for the treatment of diabetes, high blood pressure, chronic cardiovascular disease, chronic respiratory disease, chronic kidney disease, arthritis, gout, rheumatism, tuberculosis, glaucoma, thyroid disease, and cancer. The list omits mental and nervous conditions as well as gastrointestinal disorders because the drugs used in their treatment are drugs which are used by many people for general reasons and are, therefore, difficult to control.

Despite the efforts to improve the social security system which are contained in the Senate committee version of H.R. 1, I find several areas of deficiency which must be corrected if we are to provide the full measure of justice and hope which the social security program was designed to offer. In disability benefits, retirement benefits and health benefits, the Senate committee's recommendations are inadequate.

I. DISABILITY BENEFITS

A. Reduction in Waiting Period

Under the present law, a disabled worker does not become eligible for disability benefits until the 7th month of his disability; his first benefit check is not payable before the 8th month. No worker is eligible to receive disability benefits unless the disability is expected to last (or has lasted) at least 12 *full* months or to result in death.

Surely we need not ask a disabled worker to wait so long before he receives the assistance he deserves. Only one-fourth of all workers in private industry are covered by State temporary disability insurance programs. That means that three-fourths of all such workers would be forced to their own resources for the first 7 months of a major disability. The other one-fourth would not be eligible for State benefits in excess of 26 weeks. Nor is Workmen's Compensation a major factor since that program pays less than 2 percent of all workers who become totally disabled.

I propose that the present waiting period be reduced to 3 months so that an increased number of disabled workers would be eligible for benefits and for vocational rehabilitation services financed from the social security trust funds. Experience has shown that rehabilitation services are generally more effective if begun as soon after disable-

ment as possible. By reducing the waiting period for benefit eligibility, Congress will also reduce the waiting period for rehabilitation services.

In addition, I propose that the present 12-month duration requirement be eliminated. This would be consistent with private disablement insurance which pays benefits after a specified waiting period regardless of the expected duration of the disability. The families of those who have been disabled for 3 months need immediate financial assistance regardless of the number of months that need may last.

B. Test of Recent Covered Work

Under present law, the insured status requirements for social security disability benefits are far more stringent than for retirement benefits. The latter are paid if the worker is "fully insured" while the former are paid if the worker is fully insured *and* if he has at least 20 quarters (5 years) of coverage in the 40 quarter period before he became disabled.

For many disabled workers, this provision is unjust and unreasonable. Progressive illness often makes it impossible for a worker to remain in gainful employment long before disability occurs within the meaning of the law. By the time his ailment progresses to the point of disability, he has lost his disability benefit eligibility because of the test of recent covered work. Some who have failed to meet this test have worked under the social security system for 20 years or more.

The determination of disability has progressed to such a point that valid determinations can be made without reliance on the recency-of-work test as an indication that the worker would still be in the workforce if it were not for his impairment. Disability determinations are made regularly in the cases of widows, widowers, and adults who became disabled in childhood, without regard to whether they have done recent work or whether they have ever worked.

Recognizing these facts, it is time that Congress eliminated the test of recent covered work and enabled workers to qualify for disability benefits when fully insured.

C. Definition of Disability

The current law contains no greater inequity than the definition of "disability" for purposes of benefit eligibility. A worker cannot be considered disabled unless his impairments are so severe as to render him unable to engage in any substantial gainful activity. An exception, however, is made for a blind worker age 55 or older, who can qualify for benefits if he is unable to engage in any substantial gainful activity *requiring skills or abilities comparable to those required in work he had previously performed with regularity and over a substantial period of time.*

Many workers are being denied disability benefits today because they are forced to drop out of the work force by impairments which prevent them from continuing their regular jobs. For older workers, this type of impairment is especially tragic because there is usually no other job available for which he has the training or the skills. The situation is less serious for younger workers who can usually be re-trained for other employment.

We should correct this injustice by amending the definition of disability so that benefits are payable to a worker aged 55 or older if he

is so disabled that he can no longer engage in substantial gainful activity in his regular work or in any other work in which he has engaged with some regularity in the recent past.

II. RETIREMENT BENEFITS

A. *Additional Drop-Out Years*

The method used in averaging earnings has a substantial effect on the protection afforded under the social security program. Benefits for a retired worker and his family are based on his average monthly earnings in covered work over a specified number of years. In most cases, the number of years used is equal to 5 less than the number elapsing after 1950 (or, if later, after the year in which the worker reaches age 21) and up to (but not including) the year in which the worker reaches age 65 (age 62 for a woman), becomes disabled, or dies.

Since benefits payable to a man who retires at 65 this year are based on earnings averaged over only 16 years, average earnings under the program now bear a much closer relationship to earnings just before retirement than they will in the future when benefits will be averaged over a period of 35 to 38 years. In most cases, earnings averaged over such a long period will bear little relationship to earnings immediately prior to retirement.

The Senate Finance Committee rejected the House provisions of H.R. 1 which would have provided additional drop-out years over the 5 allowed under present law. That decision will result in a perpetuation of a schedule of benefits which is far too low to meet the needs of retired Americans.

I, therefore, propose that Congress amend the Social Security Act to provide one additional drop-out year for every 10 years of coverage. This provision would help assure that the social security retirement benefits of long-term workers will more accurately reflect recent pre-retirement earnings and will lessen the effect that periods of unemployment, illness, and low earnings have on benefit amounts.

B. *Earnings Limitation*

Workers who are covered by private pension systems receive their pensions when they qualify because of age, length of service, etc. Those covered by social security, on the other hand, find that they may be "fully insured" but nevertheless ineligible for benefits. This is so if they have earned income after retirement in excess of the limits set by the current law.

To perpetuate the retirement test is to say that social security is an income supplement rather than retirement insurance. Workers who have paid into the system deserve the benefits for which they have paid. They should not be forced to remain inactive in our social and economic structure in order to receive those benefits; nor should we make the pretense that social security benefits alone are adequate to meet basic human needs in the 1970's.

The increase in the earnings limitation contained in the Senate committee version of H.R. 1 is a rather small step in the right direction. I would have preferred to have seen an increase to \$2400 per year (with only a \$1 reduction in benefits for every \$2 earned thereafter) with a commitment to an eventual elimination of the earnings limitation completely. This means that a retired worker can earn \$50

a week without having a single dollar deducted from his already meager social security benefits.

More than 5 million aged live in poverty—millions more are teetering on the poverty borderline. In the past 3 years, this figure has increased while poverty among all other age groups has decreased. To prohibit older citizens from working to meet their basic needs is to force them to live their lives in the despair of poverty.

C. 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. In addition, benefit eligibility is based on age 65 for men and age 62 for women.

The Senate Finance Committee has taken an important step in correcting this inequity by adopting the House provision which phases in an age 62 computation point for men over a 3-year period. 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 years up to only age 63 taken into account; and men reaching age 62 in 1974 or later who have their benefits based on the years up to the time they were age 62. The number of quarters of coverage needed for fully insured status would also be reduced in three steps.

I see no reason to delay the full impact of the elimination of a serious inequity in the social security program. Because of the general agreement that age 62 should be the computation point for men as well as women, the provision in the Senate committee bill should take full effect immediately, with no 3-year phase-in period.

D. Lump-Sum Death Payments

Under the present law, the lump-sum death payment is three times the worker's primary insurance amount, but may not exceed \$255. As a result of this maximum dollar limitation, the amount of lump-sum death benefit no longer bears a reasonable relationship to the expenses connected with the worker's death or to the earnings levels. Since this provision went into effect in 1952, the cost of living has increased 46.3 percent. Sadly, the costs of illnesses and funerals have risen far more.

In order to meet these soaring costs, the deceased worker's survivors often reach into their monthly benefits. This may mean that, for some time after the worker's death, the family will not have sufficient income to meet its daily needs.

Congress should remove the statutory dollar limit on lump-sum death benefits and provide for a payment equal to three times the worker's primary insurance amount with a maximum payment equal to the highest primary insurance amount which any person dying on the date such individual died could have had.

In this way, not only will death benefits bear a more reasonable relationship to funeral costs, they will also bear a more reasonable relationship to earnings levels.

E. Financing of Benefits

Under present law, regular social security cash benefits are financed from contributions made by employees, employers, and the self-employed. The majority of foreign social security programs have pro-

visions for government contributions, the most common being provision for equal contributions by workers, employers, and the government.

In order to make the social security program effective in its early years, full rate benefits are being paid to people who were already old or in their middle years at the time their work was first covered under the social security program. Only a small percentage of the actual cost of the benefits being paid to these people is met by the contributions they and their employers paid. The balance of this cost will be paid by later generations of workers and their employers.

If one looks only at social security's current benefit and financing provisions and does not take into account that there will be future changes made in the program, one could conclude that young workers would get social security protection that is worth less than the combined employee-employer contributions that will be paid on their earnings. Under this sort of static analysis of the present program, that is, an analysis that assumes that wage and benefit levels remain unchanged in the future, the combined contributions of future generations of workers and their employers will be about 50 percent higher than the benefits payable to these future generations.

Moreover, a case could be made that payroll contributions are not the most desirable means by which to pay for the cost of getting the program started—that is, the cost of financing benefits for the first generation of workers. The employee-employer contribution, when viewed solely as a tax, is regressive since it falls more heavily on low-income workers than on higher-paid workers. Proponents of general revenue financing have argued for many years that a regressive tax should not be used to finance a social cost that is the responsibility of the whole Nation.

If the cost of getting the program started were to be met by a government contribution, all of the contributions paid with respect to the earnings of future generations of workers—by employers as well as employees—would be available to furnish protection for those future generations. As a result, the value of the insurance protection provided under the program for them could be made equivalent to the value of the ultimate combined employee-employer rate to be paid in the future. At the same time, the adoption of such a financing policy could make possible a substantial liberalization of benefits now without increases in social security contribution rates.

An arrangement under which the cost of getting the social security program started would be spread over the broader base of general taxation has often been proposed over the years. In 1935, the Committee on Economic Security, in explaining its plan for contributory annuities, made the following statement in its report to the President:

The allowance of larger annuities than are warranted by their contributions and the matching contributions of their employers to the workers who are brought into the system at the outset would involve a cost to the Federal government which, if payments were begun immediately, would total approximately \$500 million per year. Under the plan suggested, however, no payments will actually be made by the Federal government until 1965 and will, of course, be greater

than they would be if paid as incurred by the amount of the compound interest on the above sum.

In recommending a government contribution, a 1938 Advisory Council said:

Since the Nation, as a whole, will materially and socially benefit by such a program it is highly appropriate that the Federal government should participate in the financing of the system. With a broadening of the scope of the protection afforded, governmental participation in meeting the cost of the program is all the more justified since the existing cost of relief and old age assistance will be materially affected.

The Advisory Council of 1948 wrote the following statement in its report:

The Council believes that Old Age and Survivors Insurance should be planned on the assumption that general taxation will eventually share more or less equally with employer and employee contributions in financing future benefit outlays and administrative costs . . . in a social insurance system it would be inequitable to ask either employers or employees to finance the entire cost of liabilities arising primarily because the Act had not been passed earlier than it was. Hence it is desirable for the Federal government, as sponsor of the program, to assume at least part of these accrued liabilities based on the prior service of early retirees. A government contribution would be a recognition of the interest to the Nation as a whole in the welfare of the aged, and of widows and children.

Such a contribution is particularly appropriate in view of the relief to the general taxpayer which should result from the substitution of social insurance for part of public assistance.

The use of general revenues would be one means of making the social security system cost less for all contributors except insofar as they would pay higher income taxes, of improving benefit levels, and of meeting costs on a considerably more progressive basis.

Under the Hartke proposal for general revenue financing of cash benefits, the general revenue contribution would be equal to two-tenths of one-fifth of cash benefit outgo in fiscal 1973. The two-tenths figure would increase by one-tenth each fiscal year after 1973 eventually reaching one-fifth of benefit outgo for each fiscal year beginning with 1981. In other words, the general revenue contribution for the cash benefit program would be equal to one-twenty-fifth of benefit outgo in fiscal 1973; three-fiftieths of benefit outgo in fiscal 1974; two-twenty-fifths in fiscal 1975; one-tenth in fiscal 1976; three-twenty-fifths in fiscal 1977; seven-fiftieths in fiscal 1978; four-twenty-fifths in fiscal 1979; nine-fiftieths in fiscal 1980; and one-fifth in each fiscal year after 1980.

F. Reduced Social Security Tax Liability for Low-Income Individuals

The payroll tax has become one of the largest components in the Federal taxation system. While the size and impact of this tax has

grown rapidly, its substance has remained unchanged since the original adoption of social security. The result is that the single worker who earns \$30,000 a year pays a tax equal to that which is paid by a \$10,000 wage-earner. What is even more important, the effective rate of taxation declines as the rate of earnings increases. The worker with a \$25,000 income has a payroll tax rate of about 1.6 percent; the executive with a \$100,000 income has a payroll tax rate of about four-tenths of 1 percent; but the worker with only a \$7,000 income has a payroll tax rate of 5.2 percent under current law.

A reduction in social security tax liability for low-income individuals is necessary to offset some of the regressive nature of the current flat-rate social security tax. The amount of social security tax liability for employees and the self-employed should be based on their earnings, the low-income allowance, and a number of exemptions they claim on their income tax return.

Under a proposal which I introduced last year (Amendment #892 to H.R. 1) if a worker has earnings that do not exceed the point of first income tax liability as prescribed by the amendment, he would pay 10 percent of the total social security tax due. For each \$50 of earnings in excess of the point of first tax liability the proportion of social security tax paid by the individual would be increased by 5 percent so that earnings within the first \$50 range above the point of first tax liability would result in a tax on his total earnings of 15 percent of the social security tax. Total earnings within the next \$50 range would mean a tax rate of 20 percent of the total tax. No individual would pay more than 100 percent of the total social security tax rate.

For example, the provisions of my amendment provide that a worker claiming two exemptions would pay 10 percent of the total social security tax on earnings below \$2,750. If his earnings were more than \$2,749 but less than \$2,800, he would pay 15 percent of the total social security tax. A worker claiming four exemptions would pay at the 10 percent rate on earnings up to \$4,250 and on earnings of more than \$4,249 but less than \$4,300 he would pay 15 percent of the total social security tax. In determining income to arrive at the point of first tax liability, only wages and self-employment income covered under the social security program would be used.

Employers would withhold the adjusted social security tax from their employees. In some situations, an employee with more than one employer during the year would not have a sufficient amount of social security taxes withheld during the year because his total social security tax liability would be based on his total covered earnings. In this case, the employee would pay the difference between the tax due and the tax withheld when he filed his federal income tax return. In addition, some employees might have an overwithholding of their social security taxes. These individuals would receive a refund of their excess social security tax when they file their tax return. Similarly, for purposes of withholding the social security tax and computing the social security tax due at the end of the year, a working married couple would both be considered single individuals with one exemption each. This might require adjustments in the amount of tax due or refunded at the time the income tax return was filed.

Following is a table which describes the impact of the Hartke social security tax proposal:

PERCENTAGE OF SOCIAL SECURITY TAX PAID BY A SINGLE INDIVIDUAL AT VARIOUS INCOME LEVELS

Covered social security earnings	Percent of total social security tax paid by employee.	Effective social security tax rate ¹
0 to \$2,049.....	10	0.52
\$2,050 to \$2,099.....	15	.78
\$2,100 to \$2,149.....	20	1.04
\$2,150 to \$2,199.....	25	1.30
\$2,200 to \$2,249.....	30	1.56
\$2,250 to \$2,299.....	35	1.82
\$2,300 to \$2,349.....	40	2.08
\$2,350 to \$2,399.....	45	2.34
\$2,400 to \$2,449.....	50	2.60
\$2,450 to \$2,499.....	55	2.86
\$2,500 to \$2,549.....	60	3.12
\$2,550 to \$2,599.....	65	3.38
\$2,600 to \$2,649.....	70	3.64
\$2,650 to \$2,699.....	75	3.90
\$2,700 to \$2,749.....	80	4.16
\$2,750 to \$2,799.....	85	4.42
\$2,800 to \$2,849.....	90	4.68
\$2,850 to \$2,899.....	95	4.94
\$2,900 and over.....	100	5.20

¹ Based on employee and employer social security contribution rate of 5.2 percent each for 1972.

G. Coverage of Federal Employees

Federal employees represent the single largest group of workers in the United States who have been denied the privilege of obtaining the benefits of the social security system. As the largest single employer in the United States, the Federal Government can ill afford to continue to refuse to permit its employees the same protection as afforded almost all citizens. (See table below.)

A Federal employee should be allowed to make the choice as to whether he will come under the social security system in addition to his civil service coverage. In effect, this puts the Federal employee on the same level as a private employee since most private employees get social security coverage in addition to whatever private pension they may have.

New Federal employees would have two years from the date of their employment within which to file a certificate indicating their desire for such coverage. Existing employees likewise have two years to make such election. This election generally can be retroactive for a one-year period if the employee so chooses and if he pays the tax due.

In addition, in order that employees might have a further opportunity because of changed family or financial conditions or for other good reason to elect coverage, at the end of a five-year period each employee should have one further chance to elect coverage—there would be six months to elect coverage at that point.

The employee should continue to pay the employee tax, but there would be no employer's share to be paid. This follows the precedent established in 1965 when coverage was extended to 1½ million individuals who receive earnings in the form of tips and gratuities. At that time, the Chief Actuary of the Social Security Administration testified that extension of social security coverage of these 1½ million individuals was an actuarially sound solution to that coverage problem. This would be equally true of extension of coverage to Federal employees because they are, as a group, generally conceded to be superior risks in terms of insurance actuarial considerations.

This proposal is actuarially sound. It is in the interest of the employees because it permits them to make the election in their own interest and it is in the interest of the Federal government, not only from a budgetary point of view, but also because it closes the final large gap of coverage which remains under the social security system.

Federal civilian employment by State—1970

<i>State</i>	<i>Total employment</i>
Alabama	54,308
Alaska	14,481
Arizona	27,502
Arkansas	16,561
California	303,536
Colorado	42,314
Connecticut	20,440
Delaware	4,719
District of Columbia	192,918
Florida	69,343
Georgia	73,764
Hawaii	26,338
Idaho	8,155
Illinois	110,726
Indiana	44,447
Iowa	18,067
Kansas	22,329
Kentucky	34,685
Louisiana	27,586
Maine	15,077
Maryland	121,814
Massachusetts	63,481
Michigan	53,436
Minnesota	29,286
Mississippi	20,278
Missouri	65,028
Montana	10,292
Nebraska	15,090
Nevada	8,051
New Hampshire	5,467
New Jersey	65,870
New Mexico	25,051
New York	177,834
North Carolina	37,331
North Dakota	8,051
Ohio	96,922
Oklahoma	52,836
Oregon	24,109
Pennsylvania	137,693
Rhode Island	14,619
South Carolina	29,301
South Dakota	9,251
Tennessee	44,803
Texas	144,666
Utah	38,250
Vermont	3,653
Virginia	138,764
Washington	52,563
West Virginia	13,279
Wisconsin	25,542
Wyoming	5,186
Total, United States	2,665,093

H. Veterans

Section 402(d)(1)(B) of the Social Security Act authorizes the benefits to natural or adopted children of a parent covered by Social Security where the parent is either dead, disabled, or retired. The amount of the benefits is $\frac{1}{2}$ of the parent's basic benefit if the parent is retired or disabled; $\frac{3}{4}$ of the benefit if the parent is dead. Thus, if a parent is retired or disabled, benefits would be between \$35 and \$140 per month depending upon the salary levels of the parent's jobs, the length of time covered, and, where the family is large, the size of the family. If the parent is dead, benefits would be between \$45 and \$210 per month. Such benefits were originally available only to children under the age of 18 but a few years ago the provision was amended to permit benefits to flow to full-time students over the age of 18, but below the age of 22.

The difficulty with the existing law is that it discriminates against persons who served in the Armed Forces between the ages of 18 and 22. Their benefits are reduced by the time they spent in service.

Only 40 percent of Vietnam era veterans are currently making use of their GI Bill benefits, as compared with the 50 percent who utilized those benefits after World War II and the 45 percent after the Korean conflict.

Perhaps the most important reason for the poor rate of participation is the lack of adequate funds. Existing GI Bill benefits are, by themselves, inadequate and do not provide sufficient support for tuition, fees and living expenses. Section 1681 of title 38, United States Code, provides that the educational assistance allowance for a veteran is designed to "meet *in part* the expenses of his subsistence, tuition, fees, supplies, books, equipment and other educational costs." (*Italics supplied.*) Money provided through the Social Security Act would help fill the gap that currently exists.

To correct this injustice, I propose that, for the purpose of determining education benefits under social security for a dependent who has served in the armed forces, the period of his active duty up to 3 years which was commenced prior to the date he reached age 22 shall be deducted from his actual age. Such a change will put him on an equal basis with the non-veteran in terms of social security benefits received.

III. HEALTH BENEFITS

A. Combine Parts A and B of the Medicare Program

There is no longer any reason to maintain the separate hospital insurance (Part A) and medical insurance (Part B) segments of the Medicare program. Wage earners should be given the opportunity to pay for their medical coverage during their working years, instead, of paying a monthly premium for this protection when they are retired and living on reduced incomes.

Although 95 percent of all eligible older people have elected to be covered under the supplementary Part B program, more than 700,000 eligible persons have failed to do so. Combining Parts A and B of Medicare would mean automatic enrollment in the health insurance program for all those eligible.

Monthly premiums for the Part B Medicare program have increased from \$3.00 six years ago to \$5.80 effective July 1, 1972. The latest increase from \$5.60 to \$5.80 a month will cost the elderly of this Nation \$1.5 billion. These are people on fixed incomes who cannot afford to have any additional burden imposed on them.

While the Administration agrees that Part B premiums should be eliminated, it prefers to finance this program through the payroll tax. As I have indicated elsewhere in this statement, the payroll tax is both burdensome and regressive at its current levels. To increase that burden is both unwise and unjust for the tens of millions of working Americans who will have to bear the added cost.

One-half of Part B costs are now paid through general revenues. It is time that Congress financed the entire cost of the program in this manner.

B. Financing of Medicare

The 1971 Advisory Council on Social Security recommended that all Medicare benefits (including the combined Parts A and B) be financed one-third from employer contributions, one-third from employee contributions and one-third from general revenues. In making that recommendation, the Council said :

Among the elements underlying the Council's recommendation that Medicare financing be restructured was the problem of financing Medicare protection for social security disability beneficiaries. The Council concluded that there are insuperable problems involved in any attempt to devise an equitable method for financing supplementary medical insurance for the disabled on a current-premium basis. If, for example, a uniform premium rate for the aged and the disabled were determined based on the average per capita cost for the entire group, the aged would in effect be subsidizing from their reduced retirement incomes the high medical costs of the disabled. If the premium for both the disabled and the aged were based on the per capita cost for the aged, and the Federal Government were to meet the additional cost of the disabled from general revenues, the Federal subsidy for the disabled would represent the major part of their medical costs. On the other hand, if the disabled were to be required to pay a premium based on the per capita cost for the disabled, such a premium would be 3 times the amount paid by the aged—\$16.80 per disabled person (in contrast with the \$5.60 per month the aged will be paying in July 1971). Many of the disabled who need the protection would forgo it because they could not afford the premium. This high premium would also tend to discourage enrollment among the disabled who are in relatively good health, including some who could obtain insurance at lower cost elsewhere, with the result that there would be a preponderance of relatively high-cost and progressively worsening adverse selection, accompanied by still higher cost.

In view of the impracticality of current-premium financing for the disabled and the inequities which would result from

financing supplementary medical insurance differently for the aged and for the disabled, the Council concluded that it would be desirable to finance supplementary medical insurance for both the aged and the disabled from social security contributions and general revenues. The general-revenue share of financing the combined Medicare program should ultimately be set at one-third of the total program costs.

An appropriation from general revenue to the Medicare program will also help to pay for the coverage afforded to people already old when the program started, thus relieving younger workers of this burdensome cost. In order to make the program fully effective in the early years, people who were already old at the time it began were covered for full benefits, even though some had made no contributions to Medicare whatsoever and the rest, together with their employers, had made contributions substantially below the cost of benefits being paid to them. Thus, part or all of the cost of their benefits is now met by contributions of younger workers and future generations of workers.

I propose that this goal be achieved over a period of 4 years, beginning with a general revenue contribution of one-fifth in the first two years, one-fourth in the third year, and one-third in the fourth year.

C. Eye Care, Eyeglasses, Dentures, and Hearing Aids

The Medicare program now covers non-routine eye, ear and dental services. These three areas of affliction are all more common to those over 65 than in any other age group. Yet, although their incidence is more frequent, the elderly receive proportionately less care than other groups. For millions of older Americans, the costs of eye, ear and dental care are beyond their means.

In the area of dental care, statistics show that among those in the age range 25 to 44, the mean number of teeth filled is highest—averaging about 8 per person. But for those over 65—and under 80—that average drops to about 5. At the same time, the number of missing teeth increases from about 8 to 19.

These figures apply, of course, only to those in all ages who retain some of their own teeth. Another study in the same series, published October 1965, is perhaps even more significant. A survey of dental visits conducted during a 1-year period of 1963-64, shows that persons 25 to 44 go to the dentist more than twice as often as those over 65, even though it is apparent that the need is greater in the elderly. Part of the reason for less frequent visits, however, is that the elderly are most often those who have lost all their teeth—the survey estimates that 60 percent of those over 65 are in that category of the “edentulous.” Many of these are entirely without dentures and, because they can manage only soft foods, their general health is often impaired to some extent. Many others have a need for denture repairs or replacement of badly fitting dentures, but because of their income limitations go without seeing a dentist for these corrections.

That this is true is shown not only by the reduced number of dental visits among the elderly, but also by the much lower number of dental visits by those with low incomes. For persons with family incomes of

\$7,000 per year the incidence of visits to the dentists is more than twice that of persons with family incomes below \$4,000. There is no need, in view of the common knowledge we have acquired in recent years as to the income status of the elderly, to cite statistics on that score; it is well known that the largest low-income group in the Nation is composed of the elderly, many of whom try to exist on nothing more than their social security income.

A second area of need is that of eye care. Again, the basic facts are the same: it is the elderly who are in the greatest need because they have the greatest sight impairment, but because of their limited income they are far more likely to live with their disability rather than have it properly cared for to make their latter years as enjoyable as they might be. Again, data from the National Health Survey of 1963-1965 reveals the facts.

Here the survey is quite specific:

About 56 percent of all cases of visual impairments were among persons with a family income of less than \$4,000. The high prevalence of visual defects among persons in the lower income groups was influenced by the older age composition of these population groups.

At the time of the survey, 24.4 percent of those over 65 had incomes below \$3,000 and another 12 percent were under \$4,000. At the same time, the over-65 age group comprised nearly half—46.4 percent—of all those with visual impairment. I quote again:

The number of visually impaired persons per 1,000 population increased sharply with age. From a rate of 0.6 among young people under 25, the rate of severe visual impairments increased to 97.5 among persons 75 years and older. The corresponding rate for other visual impairments were from 6.9 to 77.4 and 131.3.

The leading cause of severe impairment among the elderly is the presence of cataracts, which is more than three times as frequent as in those under 65. In fact—and this figure may be surprising—nearly 40 percent of all visual impairments among those over 65 are due to cataracts. This, of course, is a condition which can be relieved by surgery at the proper stage, and such surgery is covered under the law as in any other surgery.

But—and this is an important part of the problem—it is obvious that a cataract must be diagnosed before it can be treated by surgery or otherwise. And at this point, the law leaves the expense of a diagnostic visit to the individual, without coverage under Part B as I am proposing. Specifically excluded are "procedures performed during the course of any eye examination to determine the refractive state of the eyes," as well as exclusion of expenses for "eyeglasses or eye examinations for the purpose of prescribing, fitting or changing eyeglasses."

The result is obvious: thousands of the elderly whose vision is impaired by cataracts do not know they have them and are thus barred from the treatment by surgery which the law provides. This is a situation which cries out for change. Providing the opportunity for the elderly to visit an ophthalmologist, or an optometrist under Part B Medicare would lead to the discovery and treatment of uncounted cases of cataract now undetected.

The third area is that of hearing impairment. Actually, the rate of hearing impairment is considerably greater than that of visual impairment, although I venture that most people, seeing so many more eyeglasses than hearing aids in use, would be much surprised to know that fact. Whereas there are an estimated 5,390,000 persons in the Nation with eye problems at least severe enough to make them unable even with glasses to recognize a friend walking on the other side of the street, more than 8½ million have by their own or a family member's account in answering the health survey questions "deafness or serious trouble hearing with one or both ears." The incidence per 1,000 of the population is, respectively, 28.8 for "all visual impairments" as defined and described earlier, and 45.7 for hearing impairments.

Again, the burden of this disability falls most heavily on the elderly. Indeed, in comparison to the rest of the population, this is an even greater problem for them, as the figures attest. Among those under 25 years of age the incidence of hearing impairment is only 9.5 per 1,000, but among those over 75, the figure is more than 33 times as great—317.2 per 1,000 or nearly a third of all persons in that age bracket. The rate for those in the 65 to 74 bracket is less, but still more than 17 times the rate for the young, or 162.1 per 1,000. And, again, there seems to be some statistical significance to the income factors:

Among persons under 65 years of age, those with a family income less than \$3,000 had a relatively high rate of hearing impairment. For persons with higher incomes, there were only slight differences between the rates of hearing loss . . . Among older persons, the rate of hearing impairment decreased steadily from 242.5 per 1,000 persons with a family income of less than \$3,000 to 173.3 per 1,000 with a family income of \$7,000-\$9,999.

In recognition of these facts, I propose that routine eye care, eyeglasses, dentures and hearing aids be covered under Medicare after the beneficiary has met an annual deductible expense.

D. Kidney Disease

In what must be the most tragic irony of the twentieth century, people are dying because they cannot get access to proper medical care. We have learned how to treat or to cure some of the diseases which have plagued mankind for centuries, yet these treatments are not available to most Americans because of their cost.

More than 8,000 Americans will die this year from kidney disease who could have been saved if they had been able to afford an artificial kidney machine or transplantation. These will be needless deaths—deaths which should shock our conscience and shame our sensibilities.

Each year, about 8 million Americans are afflicted with kidney diseases. Diseases of the kidneys and diseases affecting these organs rank among the major ailments which undermine or destroy good health. As the fifth leading cause of death in this country, the insidious nature of kidney diseases is reflected in the fact that many people who harbor infectious organisms in their urinary tract will have no warning of their disease until kidney damage is beyond repair. Of the nearly 8 million new victims each year, about 2,800,000 suffer from hypertensive renal cardiovascular diseases causing 35 percent of the deaths from kidney disease; about 2 million suffer from infectious diseases causing 18 percent of deaths; and about 3 million suffer other

diseases such as hypersensitivity, calculi, urinary abnormalities, and other ailments causing 26 percent of the deaths.

In terms of indirect costs of mortality—lost future income—kidney disease is the highest ranking killer, costing the country \$1.5 billion annually. Additionally, more than \$1 billion has to be spent each year for hospital and nursing home care, professional services, and drugs. Surprisingly, this exceeds the annual medical services costs for maternity care, or for all forms of cancer.

We have the opportunity now to begin a national program of kidney disease treatment assistance administered through the Social Security Administration, and I propose that we take that opportunity so that more lives are not lost needlessly.

E. Psychologists

Medicare contains several built-in limitations which restrict the patterns of care and availability of services for individuals suffering from mental, psychoneurotic and personality disorders.

While there are provisions for treatment of such difficulties under Part B of Medicare, they must either be provided by a doctor of medicine or by a doctor of osteopathy or as an incident to their services.

The result of this limitation has been to restrict psychological services to the point where less than 1 percent of the patients served by psychologists are over 65 years of age.

Psychology has established itself as an independent profession. There is substantial evidence that the quality of psychologists' services is almost uniformly high. In the 15 years that psychologists have had access to malpractice insurance, not one case has gone to court.

There is also significant evidence that early intervention in the treatment of mental health disorders reduces over-all costs of medical expenses.

Recently, many major insurance companies have begun to recognize psychologists as providers of health care. Thirteen states have now enacted laws which require insurance carriers to reimburse their policyholders for the diagnosis and treatment of nervous and mental disorders whether these services were rendered by psychologists or psychiatrists.

Although the Senate Finance Committee modified the current law to expand the coverage of psychologists' services under H.R. 1, the Committee failed to put psychologists on the same footing as psychiatrists and other doctors for purposes of coverage. In recognition of the state of the profession and the need which older people have for psychologists' services, I propose that qualified psychologists' services be covered under Medicare.

CONCLUSION

These are among the changes which I propose to H.R. 1 to make the social security program more responsive to the needs of the elderly and the others whom it serves. These people deserve bold action from Congress. When the Senate begins debate on H.R. 1, I intend to initiate a full discussion of the issues which I have raised in this statement in order that the legislation which is passed encompasses the type of reform which the social security program needs.

XVI. ADDITIONAL VIEWS OF MR. RIBICOFF

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II. MEDICARE-MEDICAID

I. WELFARE REFORM

I. THE PROBLEM

A. THE FAILURE OF AFDC

Everyone agrees that the present welfare system is a mess. No one supports it and it supports no one adequately.

The current public assistance program, Aid To Families With Dependent Children (AFDC) is made up of 54 different State and territorial programs, each administered by a separate jurisdiction under

broad Federal guidelines. Including the county-administered programs, there are at least 1,152 distinct operating welfare systems. By complying with Federal regulations these States and jurisdictions are eligible for Federal matching funds ranging from a Federal contribution of 50% up to 83% depending on the varying economic conditions in the States.

As a result of this diversity of programs, there is a wide variance in benefit levels and rules and regulations for determining eligibility and need. There are as many different interpretations of the Federal welfare guidelines as there are interpreters. Because of the split of authority between the States and the Federal Government, there is virtually no control at the Federal level of caseloads, administrative efficiency or mushrooming costs.

The entire welfare system is an enigma. Costs to the States are rapidly growing out of control. The present rate, in fact, would double the program cost at least every three years.

In calendar year 1971, 14.8 million people received assistance under the principal welfare programs (AFDC, Old Age Assistance (OAA), Aid to the Blind (AB)). Of this total, 10.6 million people (7.7 million children and 2.9 million adults) received AFDC payments. This represents an increase of 10.3% over the preceding year.

In the same year welfare costs amounted to \$10.8 billion, of which \$6.2 billion was spent on AFDC. These costs were up 14.7% over the preceding year.

Despite the increase in costs, the beneficiaries of the welfare system are no better off. In fact, welfare cutbacks are taking place all over the country. Payments to recipients in almost half the States have been decreased in the last two years.

Other problems abound in the welfare system. By limiting payments to those families in which the male head is absent, family disintegration is encouraged. Unemployed-father families are eligible for assistance in only 23 States.

Men who work part-time are discouraged from seeking full-time employment because their families are eligible only while they work part-time. Families in which the father works full time but who still live in poverty, are not helped at all. And yet 40% of the poor in this country live in families headed by a full-time worker.

Single people and childless couples under 65 are completely ineligible for assistance unless they are blind or disabled.

The working and training programs under the welfare system have failed to provide the social services, day care, and training and jobs needed to move employable adult recipients from the welfare rolls to the pay rolls.

B. THE FAILURE OF PAST EFFORTS IN WORKFARE

In fact, the history of welfare-manpower programs, stretching back to 1962, has been one of constant failure. Welfare work rules have paid lip service to the work ethic. But no real efforts have been made to provide the number of jobs which are truly needed to help the poor.

Between 1963 and 1966 the Congress created programs under the

Equal Employment Act, the Job Corps, the Neighborhood Youth Corps, Adult Work Experience, New Careers, Operation Maintenance and Special Impact. Statistic after statistic proved that people were being placed in training. Still, by the time Congress held hearings on public assistance in 1967, the situation as compared to 1964 had worsened. In those three years, 133,000 persons had enrolled in training, 70,000 were receiving training, and 22,000 had found jobs. Meanwhile, the AFDC rolls had increased by 800,000.

1. The WIN Program

In 1967 Congress enacted the Work Incentive Program (WIN) with the specific intent of reducing welfare dependency. While the WIN Program is the largest manpower program in operation, its current enrollment of 120,000 amounts to only about 10% of the estimated employables—male and female—on the current AFDC rolls.

During its 3½ years it has proved increasingly incapable of moving employable welfare recipients into jobs.

From July 1968 to December 1970, 511,000 people were found appropriate for referral to WIN, but only 398,000 were actually referred. Of those referred, less than 60%—229,000—were actually enrolled. In the final analysis only 20,000 AFDC cases—10% of enrollments—were closed following WIN. Yet during this time span the welfare population increased by 1,169,000 families.

2. The Talmadge Amendments

The latest effort to restructure welfare-manpower programs occurred in December of 1971 when Congress enacted the so-called Talmadge amendments to the WIN program. These provisions set forth specific criteria regarding who is required to register for employment for training and provide financial incentives and penalties to assure State compliance with new work referral rules. The amendments also set priorities for the limited training resources available.

While the Talmadge amendments do patch up some of the problems in the WIN program, they should not be viewed as welfare reform. The WIN-Talmadge program continues a program in which lines of responsibility are divided and blurred between the Department of Labor, HEW and State and local agencies. State employment service agencies will continue to be dependent on local welfare agencies as their sole source of supportive services, regardless of whether these agencies can supply the services. No one agency will have command responsibility and the confusion between the two Federal agencies and the multi-jurisdictional State and local agencies will continue under WIN-Talmadge.

The WIN-Talmadge program continues the inequitable AFDC situation in which families headed by unemployed fathers will continue to be ineligible in a majority of states and low-income families in which the father works full time will not be covered at all. This perpetuates a welfare system which gives a father an incentive to leave his family so that they can receive benefits. The WIN-Talmadge programs leaves untouched the wide variance between states in benefit levels. Income supplements to the working fathers—making it always more profitable to work than receive welfare—would not be provided under present law.

II. THE FINANCE COMMITTEE BILL—ANOTHER WORKFARE PROPOSAL

The Finance Committee proposal offers more of the same workfare programs which have failed in the past.

The program approved by the Senate Finance Committee represents a long step backward on the road to welfare reform.

The Finance Committee proposal retains the existing, widely discredited State AFDC programs for mothers with young children, and adds on top of it another program for families with an overlapping jumble of wage subsidies, social security tax rebates, work disincentives and subpoverty wage programs.

Rather than coordinate and improve the operation of our welfare program, the Committee proposal compounds the lack of coordination by scattering new programs throughout the Federal government. The new "workfare" programs would be administered by the Departments of HEW, Treasury and a new Federal Work Administration in addition to the 1152 administrative units at the state and local level which already handle the AFDC program.

The Committee's proposals supposedly increase work incentives but the combined effect of the disparate array of income supplements, tax rates and job programs is to discourage people from working. Welfare recipients will be in a continuing state of confusion about how to relate to all the offices and programs involved.

Even more importantly, the Committee bill does nothing to improve the level of benefits AFDC recipients receive, or to move in the direction of nationally uniform eligibility standards and payment levels.

The costs of the Committee proposal would exceed those of H.R. 1 by over \$6 billion and would cover some 30 million people. Yet much of the money for the program would not be concentrated on the poorest of the poor. Instead, large amounts would go to those earning relatively more money. Administrative costs would also be increased since records would have to be maintained and transferred between many different Federal, State and local agencies.

A more detailed analysis of the Committee proposal illustrates the confusion and inequities inherent in the plan.

A. WAGE SUBSIDY

A wage subsidy would be paid by the newly created Work Administration equalling three-fourths of the difference between a low wage in private industry and the minimum wage. The Committee report assumes that the minimum wage is \$2.00. Thus it was the figure \$1.50 when referring to $\frac{3}{4}$ of the minimum. But since the bill itself speaks in terms of $\frac{3}{4}$ of the minimum wage—presently \$1.60—I will assume that present law is in effect. Thus if a worker is making \$1.20 per hour the wage subsidy would be 30 cents an hour— $\frac{3}{4}$ of the difference between \$1.20 and \$1.60. Such a subsidy would encourage employers to pay low wages since they could expect the Federal Government to pick up the cost of higher wages. In addition to this wage depressant effect, workers would be better off only if they worked longer hours. Nothing would be done to upgrade hourly wages.

This Nation shall avoid a policy of encouraging workers to work for sub-poverty wages. Raising wage levels would be wiser. Furthermore, recipients would not be automatically eligible for the wage subsidy. They would have to apply to the local employment service—agencies which have consistently fallen down on the job of providing jobs and services to the poor.

The wage subsidy would only apply to jobs paying between \$1.20 and \$1.60 per hour. Thus, the most impoverished workers—those in jobs which pay less than \$1.20—would not be aided. This group, comprising well over half a million individuals, is in dire need of assistance.

B. 10 PERCENT PAYMENT

Participants referred to private sector jobs would receive an additional subsidy of 10% of wages covered by Social Security. This payment, made by the Internal Revenue Service, would only apply to the base hourly wage, not to the wage subsidy portion of hourly income. This payment would be phased out as income rises above the poverty line at a 25% rate, thus dampening any incentives to move above the poverty line.

Such a proposal rewards a family with \$4,000 of earnings twice as much as a family with \$2,000. It thus provides the least to those with the greatest need.

Administratively this proposal would involve the keeping of a huge volume of records and the maintenance and transfer of records between IRS, the Work Administration and perhaps other agencies. Millions of tax records would become a part of the welfare maze.

While I share the view of the Committee that it is desirable to relieve the poor of the burden of paying Social Security taxes—I have publicly supported a Social Security rebate to impoverished working Americans—I cannot accept the Committee proposal since it is part and parcel of an unworkable and inequitable overall plan.

The legislation I have developed—Amendment 559—would provide relief from both Social Security and income taxes through the earnings disregard feature. That is, in determining what is income for the purposes of computing the welfare payment, my proposal disregards the first \$720 of income, 40% of additional income, and amounts paid for Social Security and income taxes.

C. WORK ADMINISTRATION

While the vast majority of welfare recipients are unemployable, the Finance Committee proposal concentrates heavily on the small minority who are employable. The main structure of the program for families with an employable individual is the Work Administration.

The Work Administration would attempt to provide job placement, job development, employability plans and manpower training. All em-

ployable adults registering for welfare would be required to become employees of the Work Administration as a condition of receiving assistance. The Work Administration would attempt to place registrants in private jobs at the minimum wage or "subsidized" public or private jobs at less than the minimum wage. The 10% supplement would be provided for those taking private jobs and for the non-subsidy portion of subsidized public or private jobs.

Those not so placed in "regular" jobs would become direct employees of the Work Administration at \$1.20/hour, far less than either the poverty line or the Federal minimum wage. These employees would receive no wage subsidy or 10% supplement. In fact, the Work Administration employees would be in limbo between Federal and private employment—ineligible for Social Security, unemployment compensation or workmen's compensation.

These direct Work Administration employees would be required to perform "useful work which can contribute to the betterment of the community." For mothers with younger children, training to improve the quality of life (improve homemaking, beautifying apartments, acquiring consumer skills) would be provided. The Work Administration would also provide temporary employment with reimbursement to the Work Administration. In effect, the Federal Government would be maintaining a sub-poverty wage manpower pool at the disposal of the business community.

The concepts embodied in the Work Administration are confused and often erroneous. While the basic idea of making the Federal Government the employer of last resort is a sound one, the downgrading of public service jobs relative to private sector employment is unfortunate. The emphasis on providing "incentives" for workers to move into "regular" private employment by paying Work Administration employees only \$1.20/hour is absurd at best.

A major problem with the Committee's proposal is that the private sector does not have sufficient jobs. In fact, over 5 million Americans are unemployed. Thus, even with extraordinary motivation, a Work Administration employee cannot escape his \$1.20/hour job if there are no other jobs. He is doomed to remain at a menial \$1.20/hour salary—\$1,500 below a poverty level wage on an annual basis. And the Corporation, by paying only \$1.25 an hour for those in manpower training is discouraging rather than encouraging participants to upgrade their skills and increase their income.

Rather than discouraging public service employment we should be fostering it. It has been estimated that State and local government could utilize as many as 4 million people in public service activities of all kinds—conservation, education, health, consumer protection, recreation, sanitation, criminal justice, child care. It should be obvious to all that our inner cities are decaying, our air and water getting dirtier and our public services becoming increasingly unable to meet the challenge of providing us with the manner of existence we as Americans desire. Public service jobs should provide workers with at least a poverty-level wage. In this way we can both fight poverty and improve our communities.

Under the Committee bill those unable to work would continue to participate in the widely discredited AFDC system. Generally each

State would decide the level of assistance it will provide. But Federal financial participation in the program would be changed from the pres-

D. ASSISTANCE TO UNEMPLOYABLE ADULTS

ent matching formula to a bloc grant approach. By putting a ceiling on Federal aid, the Committee bill will discourage the States from raising welfare payments. The bloc grant approach would allow only low benefit States to raise their benefit levels. Under the Committee bill a State's grant for 1973 would equal the 1972 Federal share, plus an additional amount equal to as much as one-half of the 1972 State's share. But less than one-half the State share would be provided if that amount were sufficient to bring family income up to a level of \$1,600 for a family of two, \$2,000 for three, or \$2,400 for four. Alternatively, a State could opt for 110% of the 1972 Federal share. In future years the bloc grants would be reduced under the assumption that the Committee's workfare program is reducing the welfare rolls. Given the past failure of welfare-workfare programs it appears that the reduced size of the payments will mean only smaller and smaller assistance payments to families in need rather than stable payments to a shrinking welfare population.

III. AMENDMENT 559—THE RIBICOFF ALTERNATIVE

The legislation I and others have introduced to reform the American welfare system is based on the study of the Commission on Income Maintenance Programs (The Heinenan Commission) which was assigned its task in January of 1968 by President Johnson. Following over a year and a half of study, the Commission issued its recommendations to create a Family Assistance Plan. Based in large part on the work of the Commission, President Nixon introduced a Family Assistance Plan in October of 1969.

During the three years of debate on welfare reform the President has revised and re-revised the originally sound proposal to a point where, in its present form in the House-passed H.R. 1, it is unacceptable.

The elements of the proposal we have introduced build on the originally sound proposal.

A. NATIONAL INCOME GUARANTEE

Amendment 559 would establish a national Federal floor of benefits at a level of \$3,000 for a family of four in the first year. Federal payment levels under the program would increase over a five year period so that all people in need of public assistance would be receiving at least a poverty level income by the time the program is fully federalized.

My proposal would move the Federal payment up each year to assure that by fiscal year 1977 all Americans received at least a poverty level income. As introduced in October of 1971, the Amendment provided for a Federal payment level of \$3,000 in fiscal year 1973, 75% of the poverty level in fiscal 1974, 80% of the poverty level in fiscal 1975, 90% of the poverty level in fiscal 1976 and 100% of the poverty level in fiscal year 1977.

B. STATE SUPPLEMENTATION OF BENEFITS

The proposal would require States whose payment levels now exceed the Federal guarantee level to make supplemental payments to assure that no one receives less under welfare reform than he or she now receives under the present system.

This would be accomplished by requiring States to maintain the payment levels they had as of January 1971. This would result in a rescinding of the major cutbacks in welfare payments made over the last few years.

The State maintenance payment would also have to include the bonus value of food stamps in recognition of the elimination of food stamps for recipients under the Family Assistance Plan

C. UNIFORM FEDERAL SYSTEM

Amendment 559 would establish, for the first time, uniform Federal eligibility standards as well as uniform national benefits. At present the welfare system is administered by 1,152 separate administrative units whose competence and efficiency varies widely. In effect there are as many different interpretations of the welfare system as there are interpreters. Uniform rules and payments would eliminate any incentive for persons to migrate from one State to another to take advantage of a new generous payment plan in a different State.

D. AID TO WORKING POOR: PILOT PROGRAMS

Amendment 559 includes the principle of aiding low-income intact families (the "working poor"). Under present law a family cannot receive assistance if a man is present in the home and is working. This often creates a situation in which the husband quits his job and deserts the family so that it can take advantage of higher welfare benefits.

The innovative program to provide income supplements to the working poor (the Opportunities for Families Program) was not intended to go into effect until January 1, 1974. I have proposed that testing and demonstration projects of such a system be tried out before implementation is carried out on a national level.

I have been increasingly concerned over the difficulties encountered by social legislation created in Congress. Laws that have been approved in legislative chambers and acclaimed as social milestones have not passed muster in the field. The poverty programs of the 1960's promised an end to poverty. Instead, they raised hopes and expectations but did little to lessen the poverty problem. The result was increased anger and frustration.

This tendency to seek answers in position papers and academic exercises must give way to the experience of the real world.

In summary form the pilot projects would be designed as follows:

1. *Test of Working Poor Provisions*

The pilot projects would be a test of the impact of the provisions of H.R. 1 which provide benefits and related employment services to working poor male-headed families.

2. *Four Program Purposes*

The projects will study:

(a) **Work Experience:** The work experience of participants—types of jobs, hours and earnings.

(b) **Effect on Families:** Effect of the program on the composition and structure of families.

(c) **Services:** Types of services that are needed for the working poor.

(d) **Participation:** The extent to which families who are eligible for the program participate.

3. *Administrative Purposes*

An additional important purpose of the projects will be to provide information for administrative planning for the new program to cover the working poor to be established nationally on a date specified in H.R. 1, following a report to the Congress on findings from the pilot projects. Important administrative questions to be studied are:

(a) How soon do applicants apply for benefits.

(b) Feasibility of the initial application form—whether the information sought can be provided by the family head and whether this information is complete enough to calculate payments and provide an adequate basis for an automated audit.

(c) The extent to which necessary documentation such as birth certificates of children, marriage licenses, W-2 forms, business records, etc. can be provided by families.

(d) The proportion of eligible individuals who do not have Social Security numbers, or have them but do not know where they are.

(e) Qualification and training needs of personnel.

(f) The workability of regulations, including appeals procedures.

(g) Information needed to design a data storage and retrieval system so that internal consistency checks and audits of the reports can be conducted.

(h) Estimates of administrative cost and personnel needs for operating nationwide.

4. *Number of Areas*

The number of sites for pilot projects would be limited. The reason for this is that HEW needs to be able to set up and conduct the projects so that a report can be made to the Congress in time for its consideration before the effective dates of the new program to cover the working poor.

5. *Form*

The form of the pilot projects would be "pre-post." That is, HEW would measure important population characteristics before the test and after the test to determine the effect of the new program.

6. *Responsible Agencies*

The pilot projects will be undertaken by the Secretary of HEW and the Labor Department with the Secretary of HEW having lead responsibility.

Providing aid to the working poor will assure that it is always more advantageous financially to work than to simply receive welfare and it will remove the present system's incentive to break up homes.

Under the proposal to aid the working poor, the recipient could work without losing all his benefits. His welfare check would not be cut off automatically when he works but would instead be phased out gradually under a formula.

In determining the size of the welfare payment, the first \$720 of earnings is entirely disregarded and 40% of additional earnings is ignored. Under a \$3,000 guaranteed income plan let us look at a typical example of how the formula works:

Example A: Assume a family of four with earnings of \$3,600. In determining the size of the FAP payment, the first \$720 is deducted, leaving \$2,880. Then deduct 40% of \$2,880 (since our earnings disregard is \$720 plus 40% of income). This leaves \$1,728 of income. Since our guaranteed income level is \$3,000, we need to add \$1,272 to reach the \$3,000 level. Thus the FAP payment to a family of four making \$3,600 would be \$1,272. Adding \$1,272 to earnings of \$3,600 gives the family \$4,872. In this case the family has been moved out of property by the Family Assistance Plan.

Under present law, no Federal benefits at all are payable to this family in any State because the father is in the home and is not unemployed. If the family with \$3,600 in income lived in a State which paid \$3,900 a year they would find it more advantageous to quit work and go on welfare. But the Family Assistance Plan, by supplementing earnings, removes the incentive to quit work. In fact it provides an incentive to work because working income will be supplemented.

Under my proposal, if the pilot programs are successful, benefits to working poor families would totally phase out at a level of \$5,720. It is at this point that, after the earnings disregard formula is used, the

countable income is \$3,000, making the family ineligible for supplements. (Deduct \$720 from \$5,720, leaving \$5,000. Then deduct 40% of the remaining \$5,000, leaving \$3,000. With \$3,000 in countable income, \$0 is needed to reach the \$3,000 guarantee level.)

The earnings disregard formulas have varied in different bills and have caused a great deal of controversy. It is argued that the more liberal the earnings disregard—e.g., \$720 plus 50% rather than \$720 plus 40% or 33%—the greater the incentive to work. Intuitively, this assessment seems correct. The more money a family can earn without losing some of its welfare benefits the more likely they will be to continue work. Studies, however, are inconclusive about whether the size of the earnings disregard is a critical factor as to whether a family will move into or drop out of the labor force. In fact, the New Jersey Income Maintenance Experiment thus far has not shown the relationship one would intuitively expect.

On the other hand, the level of the break-even point—that level at which benefits phase out (\$5,720 in the case of Amendment 559)—is of critical importance in terms of cost and public acceptance of the bill. By providing supplements, however small, to families with incomes at the \$6,000 level, the resources available to aid those in poverty are spread thinner. At the \$5,000 and \$6,000 income levels we find many families bunched up in what could be called a bell curve pattern. There are fewer families at the extremes of poverty, but many more as income goes up. It would be wiser to concentrate our resources on the poorest of the poor. I believe that my earnings disregard formula of \$720 plus 40% accomplishes that purpose, but our experience during the pilot period would give us the most reliable information in this area.

The following chart illustrates the way in which the nucleus of eligible recipients and the cost of the program increases as the “earnings disregard” and payment levels are liberalized.

For example, a \$3,000 plan with a 67% tax rate covers 25.5 million people at a cost of \$9.4 billion. The same payment level with a 50% tax rate covers 39.3 million people and costs \$11.6 billion.

In view of our limited resources and desires to concentrate these funds on the poorest of the poor we set a rate of 60% with a payment level of \$3,000. Such a program will potentially make 30.8 million people eligible and cost \$10.4 billion. It should be emphasized that such costs and eligibility are the outside limits if everyone takes advantage of the program. Realistically, cost and coverage will be smaller.

TABLE 1
BENEFIT LEVELS AND TAX RATES—PAYMENTS AND CASELOADS

Maximum benefit for family of 4	Tax rates					
	50 percent		60 percent		67 percent	
	Payments (billions)	Eligibles (millions)	Payments (billions)	Eligibles (millions)	Payments (billions)	Eligibles (millions)
\$2,400.....	7.9	28.1	7.1	22.8	6.4	19.4
\$2,600.....	9.1	31.5	8.2	25.4	7.4	21.4
\$2,800.....	10.3	35.0	9.3	28.1	8.4	23.4
\$3,000.....	11.6	39.3	10.4	30.8	9.4	25.5
\$3,200.....	12.9	43.8	11.6	33.6	10.5	27.7
\$3,400.....	14.3	48.6	12.8	36.6	11.6	30.2
\$3,600.....	15.7	53.6	14.1	39.8	12.7	32.9

Note: Under Ribicoff amendment, welfare recipients keep first \$720 of earnings plus four-fourths of the remainder (a 60% tax rate).

E. FISCAL RELIEF TO THE STATES

As the Federal Government takes over the welfare system in the next five years my proposal would provide billions of dollars of fiscal relief to the States.

The relief mechanism of this proposal works as follows. Those States which are required to make supplementary payments (all States that presently pay more than the Federal guarantee level—\$3,000 in the first year) would receive 30% Federal matching for their supplementary payments. In addition these States would be guaranteed that their welfare costs not exceed 90% of calendar 1971 costs for fiscal 1973, 75% for fiscal 1974, 50% for fiscal 1975, 25% for fiscal 1976, and 0% for fiscal 1977. At the beginning of fiscal 1977, then, the States would be entirely out of the welfare business.

An emergency fiscal relief measure which I have introduced, Amendment 820, would provide immediate relief to the financially hard-pressed States. In the period before the Family Assistance Plan takes effect my emergency proposal would assure the States that in fiscal 1972 and fiscal 1973 welfare costs would not exceed 1971 levels.

The following charts illustrate the savings to the States under my proposal.

TABLE 2
RIBICOFF EMERGENCY WELFARE FISCAL RELIEF MEASURE (AMENDMENT 820
TO H.R. 1)

State	State savings (in millions)		State	State savings (in millions)	
	Fiscal year 1972	Fiscal year 1973		Fiscal year 1972	Fiscal year 1973
Alabama.....	\$6.2	\$10.1	Nebraska.....	\$4.7	\$8.2
Alaska.....	1.5	3.5	Nevada.....	.2	1.5
Arizona.....	1.7	36.1	New Hampshire...	1.3	2.2
Arkansas.....	2.6	5.5	New Jersey.....	24.0	45.8
California.....	-98.6	169.5	New Mexico.....	.4	1.0
Colorado.....	4.1	8.9	New York.....	78.3	153.9
Connecticut.....	12.0	18.1	North Carolina...	6.4	10.5
Delaware.....	2.6	4.4	North Dakota.....	.6	1.1
District of Columbia.....	19.1	54.5	Ohio.....	30.9	63.8
Florida.....	11.0	100.6	Oklahoma.....	14.0	14.0
Georgia.....	13.0	22.1	Oregon.....	2.6	4.8
Hawaii.....	5.1	8.0	Pennsylvania.....	38.1	67.7
Idaho.....	.6	1.8	Rhode Island.....	3.9	7.2
Illinois.....	100.4	189.1	South Carolina...	1.7	4.9
Indiana.....	20.3	33.9	South Dakota.....	1.0	1.5
Iowa.....	1.7	4.9	Tennessee.....	2.0	3.9
Kansas.....	2.4	7.4	Texas.....	2.7	15.0
Kentucky.....	2.9	6.7	Utah.....	2.0	3.4
Louisiana.....	0	25.7	Vermont.....	1.9	3.9
Maine.....	2.5	2.8	Virginia.....	9.4	22.0
Maryland.....	14.7	44.4	Washington.....	1.1	7.3
Massachusetts...	39.5	69.0	West Virginia.....	2.9	2.9
Michigan.....	69.0	111.7	Wisconsin.....	12.0	19.9
Minnesota.....	8.5	16.9	Wyoming.....	2.0	.6
Mississippi.....	3.8	5.3	Possessions.....	.2	1.7
Missouri.....	6.1	10.7			
Montana.....	.2	.5	Total.....	694.3	1,440.7

TABLE 3.—STATE-BY-STATE FISCAL SAVINGS
COMPARISON OF CURRENT WELFARE COSTS, H.R. 1 SAVINGS, AND SAVINGS UNDER THE RIBICOFF BILL 1
 [In millions]

	Calendar year 1971 costs	Fiscal year 1974		Fiscal year 1975		Fiscal year 1976		Fiscal year 1977	
		H.R. 1	Ribicoff	H.R. 1	Ribicoff	H.R. 1	Ribicoff	H.R. 1	Ribicoff
Alabama.....	\$32.6	\$32.4	\$32.5	\$38.4	\$38.4	\$45.4	\$45.9	\$47.2	\$47.4
Alaska.....	9.4	2.5	3.1	3.1	5.5	3.7	8.9	4.4	11.3
Arizona.....	18.6	21.5	30.5	22.6	31.7	23.8	33.9	25.2	35.2
Arkansas.....	15.4	19.7	19.7	20.4	20.8	21.3	21.3	22.1	22.2
California.....	960.2	234.9	578.7	294.9	770.4	356.5	957.5	402.5	7,135.0
Colorado.....	41.8	13.3	37.1	16.6	40.7	19.8	44.4	21.5	47.5
Connecticut.....	53.3	21.3	26.6	25.7	39.4	30.2	56.6	34.8	74.9
Delaware.....	6.8	1.8	7.5	2.1	7.5	2.5	8.5	3.0	8.6
District of Columbia.....	34.1	12.6	34.5	17.0	39.3	21.5	45.0	23.4	47.1
Florida.....	98.0	170.3	180.0	177.8	190.4	185.3	200.8	192.9	211.2
Georgia.....	44.4	57.8	59.8	53.4	63.4	55.0	66.1	56.7	68.8
Hawaii.....	17.2	7.0	19.5	7.8	22.0	8.6	23.1	9.6	25.2
Idaho.....	6.2	1.5	3.9	1.9	6.7	2.2	6.7	2.8	6.8
Illinois.....	224.6	62.1	119.1	78.9	200.1	95.6	219.5	112.4	235.8
Indiana.....	27.0	8.6	19.7	10.5	26.6	12.6	32.7	14.7	36.6
Iowa.....	43.4	26.7	54.2	28.6	56.4	30.5	59.6	32.6	61.8
Kansas.....	28.3	14.2	38.6	15.6	40.8	17.0	43.0	18.7	45.3
Kentucky.....	28.2	12.6	36.6	13.6	38.0	14.5	39.4	15.5	41.8
Louisiana.....	50.4	65.4	65.4	68.5	68.5	71.7	71.9	74.9	74.9
Maine.....	14.6	3.6	11.4	4.4	14.2	5.4	17.9	6.4	21.4
Maryland.....	54.6	41.9	67.7	44.7	72.1	47.5	75.5	50.4	79.9
Massachusetts.....	191.2	44.3	65.3	57.3	124.4	70.4	181.5	83.7	228.6
Michigan.....	174.1	45.4	121.1	58.2	169.2	71.2	203.5	84.2	216.7
Minnesota.....	61.0	15.2	26.7	19.4	50.7	23.8	73.1	28.1	77.4

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Mississippi.....	15.4	23.3	23.5	24.2	24.2	25.2	25.3	26.4	26.8
Missouri.....	52.4	12.1	17.9	14.9	34.5	20.5	51.7	22.6	59.9
Montana.....	5.1	2.5	7.1	2.7	7.1	2.9	7.1	3.2	7.3
Nebraska.....	12.2	3.1	4.7	3.9	6.6	4.7	10.8	5.6	14.9
Nevada.....	3.2	1.1	1.1	1.2	2.5	1.2	3.3	1.8	4.2
New Hampshire.....	11.8	2.3	3.8	2.9	5.6	3.6	9.5	4.4	13.6
New Jersey.....	181.4	50.1	67.9	64.4	122.2	78.6	182.5	93.1	240.4
New Mexico.....	12.3	7.3	16.6	7.8	17.7	8.2	17.8	8.7	18.9
New York.....	663.4	188.4	375.1	238.7	622.6	289.2	749.7	339.6	980.3
North Carolina.....	33.3	31.9	42.8	33.0	45.1	34.1	46.4	35.2	48.7
North Dakota.....	4.4	1.2	1.7	1.2	3.1	1.4	4.2	1.8	5.7
Ohio.....	11.4	64.0	129.6	69.3	138.2	74.6	145.8	79.9	154.3
Oklahoma.....	46.8	38.3	52.5	40.2	54.2	42.0	56.8	43.9	59.3
Oregon.....	31.7	15.9	41.0	17.4	43.2	18.9	45.5	20.5	47.6
Pennsylvania.....	265.1	51.3	125.9	69.9	217.5	88.5	305.5	107.2	331.5
Rhode Island.....	20.9	6.3	15.6	7.7	22.3	9.3	26.3	11.0	28.5
South Carolina.....	8.3	13.8	13.8	14.5	14.8	15.2	15.2	16.0	16.4
South Dakota.....	5.4	2.5	3.2	2.8	4.0	3.3	6.5	3.7	7.9
Tennessee.....	34.7	34.2	43.0	35.1	45.2	36.1	47.4	37.0	49.6
Texas.....	85.9	57.1	108.4	59.7	113.1	61.4	116.9	65.1	123.7
Utah.....	9.6	3.4	11.7	3.6	12.7	3.9	12.7	4.3	13.8
Vermont.....	6.4	1.1	1.6	1.3	2.6	1.7	5.2	2.1	6.9
Virginia.....	34.6	10.4	14.2	12.9	21.6	15.5	34.2	18.2	44.3
Washington.....	71.4	11.4	30.6	15.9	48.0	20.6	63.3	25.2	78.7
West Virginia.....	16.0	18.3	20.8	18.7	21.9	19.2	23.0	19.7	24.1
Wisconsin.....	40.4	33.3	54.7	35.5	58.3	37.6	60.9	39.9	64.6
Wyoming.....	2.6	1.2	3.3	1.3	3.4	1.5	3.4	1.9	4.6
Guam.....	.6	.2	.4	.2	.5	.3	.6	.3	.6
Puerto Rico.....	19.2	26.1	26.6	27.6	27.9	29.1	29.2	30.7	30.5
Virgin Islands.....	.7	1.1	1.2	1.2	1.2	1.2	1.2	1.4	.3
Total.....	4,041.0	1,643.8	2,919.5	1,911.1	3,879.0	2,185.5	4,644.1	2,438.1	5,369.3

¹ Savings are derived by subtracting proposed costs from current law costs of the same year. Administrative savings are included.

F. WORK REQUIREMENTS

Everyone agrees that able-bodied adults should have the opportunity to work if employable. My proposal incorporates this principle. Work requirements, however, should be placed in perspective.

The fact is that only a small percentage of those presently on welfare are employable. Of the 14.8 million welfare recipients in 1971, the majority (50% or 7.7 million) are children. Another 4.2 million are aged (15%) blind or disabled (9%). Some 2.5 (18%) million are mothers with children.

Some 14% of these women already work and 7% are in work training. An additional 35% could work if adequate day care programs were available for their children. 5% would have employment potential following extensive social rehabilitation efforts, and the remaining 40% have little employment potential because they care for small children at home, have major physical or mental incapacities or other insurmountable work barriers. Despite all these barriers 70% to 80% want to work.

This leaves us with able-bodied unemployed adult males who make up less than 1% of the welfare population. Of these, more than 80% want to work according to a government-sponsored study. And about half of these are enrolled in work training programs hopefully designed to make them more employable. This is hardly the picture of millions of slackers making a full-time job out of avoiding work.

What the adults on welfare lack is not the incentive to work, but the opportunity to work.

My proposal would give them that opportunity.

Amendment 559 provides a system in which all potential welfare recipients register for welfare assistance under one program jointly operated by the Departments of Health, Education, and Welfare and Labor. If determined to be unemployable the welfare recipient becomes a part of the Family Assistance Plan (FAP) which guarantees an income level of at least \$3,000 in the first year.

Those determined employable according to criteria set forth in the Amendment would come under the jurisdiction of the Opportunities for Families (OFF) program. These persons would be given a job or an employability plan and training leading toward a job. No one would be required to undergo training unless a job were available at the end of the training.

The following people would be automatically exempt from the work requirement:

- (a) mother or other relative caring for a child under age 6
- (b) those unable to work because of illness, incapacity or advanced age
- (c) the mother or other female caretaker of a child if the father or another adult male is in the home and is not otherwise exempted from the requirement of registration
- (d) a child under age 16 or in school
- (e) one whose presence in the home is required because of the illness or incapacity of another household member.

There are additional safeguards to assure that mothers are not forced to abandon their children in order to enter the labor marketplace.

Mothers with children over age six may be required to enter the job

market only if a suitable job paying at least the minimum wage and adequate day care is available.

Suitable employment is determined based on the individual's health and safety, his physical fitness, his prior training, experience and earnings, the length of his unemployment, his prospects for obtaining work, and the distance of the work from his residence. Because the number of such suitable jobs paying the Federal minimum wage is small, this will reduce the number of private sector jobs available. Consequently the Amendment provides for the Federal support of 300,000 public service jobs at State and local government levels to aid in providing basic governmental services ranging from hospital work to environmental protection to health and child care.

The other major protection against forced work is the day care "adequacy" requirement. My proposal requires that all day care be no less comprehensive than the 1968 Federal Interagency Day Care Requirements. No mother should be forced to place her child in a situation in which standards of day care are low or non-existent. At the present time the 1968 standards are the best developed. Given the fact that there are less than 700,000 day care slots in licensed day care facilities in the United States, most of which do not meet these standards, it is clear that the lack of adequate day care will provide an exemption for many mothers. Hopefully, the \$1.5 billion in funds for day care and the \$100 million for child care facilities in my amendment would initiate the process of providing an adequate day care system.

Finally, my proposal recognizes that even with expanded day care and public service employment programs, there still will be a shortage of jobs. Therefore, the Amendment sets priorities for the distribution of job opportunities.

First priority would be afforded to unemployed fathers and mothers who voluntarily register. The available jobs will probably be exhausted with this group.

Second priority goes to other adult non-family heads such as part-time workers and youths who have finished school.

Third priority is given to those who are already working full time in low-paying jobs. And finally, in the last priority category are other adults such as mothers who don't wish to leave their children. These priorities, incidentally, are incorporated in the Talmadge-WIN amendments.

It is clear that a major point of debate in welfare will center on the definition of employability. I believe that the work requirements written into my proposal strike the proper balance between those who can work and those who can't.

G. ADMINISTRATIVE PROCEDURES AND RECIPIENT RIGHTS

The present welfare system is demeaning to the recipients in that it unnecessarily interferes in their private lives and fails to provide adequate safeguards to assure fairness and due process.

Amendment 559 would require all hearings and procedures to comply with the provisions of the Administrative Procedure Act.

Existing HEW regulations governing administrative procedures are generally comprehensive and fair. Some provisions in H.R. 1 would unnecessarily alter these regulations to the detriment of the needy or add needless restrictions.

Our amendment would remedy this situation as follows:

1. *Termination of Benefits*

H.R. 1 would terminate benefits automatically unless a family submitted a report within 30 days after the close of any quarter during which it received benefits, containing any information on income and expenses necessary for determining what the correct amount of benefits should have been. In view of *Goldberg v. Kelly* (397 U.S. 254 (1970)) which invalidated arbitrary terminations of payments without hearings, the automatic cut-off provisions of H.R. 1 rest on tenuous constitutional ground. As *Goldberg* pointed out:

To cut off a welfare recipient in the face of . . . "brutal need" without a prior hearing of some sort is unconscionable, unless overwhelming considerations justify it. . . . Against the unjustified desire to protect public funds must be weighed the individual's overpowering need . . . not to be wrongfully deprived of assistance.

Since 46% of all disputed welfare administrative payment determinations are reversed after hearings, the onus of administrative mistake, when it manifests itself as a wrongful eligibility determination, should not fall on eligible but wrongfully rejected applicants who may literally starve while awaiting a hearing.

My proposal incorporates the Administration's original 1969 language for H.R. 1, which assured continued welfare payments while hearings were held to settle disputed claims. Such a change would protect legitimate recipients from the disaster of a total cut-off while allowing the Secretary of Health, Education, and Welfare to use his power to bar patently frivolous claims.

2. *Written Opinions Required*

My amendment would require that a written opinion detailing the reasons for a hearing be submitted promptly to the claimant. Recipients, whose very lives may be at stake, should not be subject to the whim or caprice of an impersonal administrative bureaucracy. All rights and responsibilities of welfare recipients should be clear and justifiable.

3. *Right to Counsel*

Every claimant would be assured of the right to counsel of his own choosing by my amendment, assuring recipients that they could rely on the increasing number of welfare "lay advocates"—non-lawyers who have specialized in both the legalities and practice of welfare law. These people serve without charge and have enabled many recipients to cope with the bureaucratic welfare maze on a more equitable basis.

The broad language of H.R. 1 limiting representation in welfare hearings to those who possess certain undefinable qualities of character and reputation may easily be used to prevent participation in the hearing process by members of groups organized to aid welfare recipients.

4. *Standards for Hearing Examiners*

H.R. 1's provision waiving standards for welfare hearing examiners would be eliminated under my amendment. There is no reason why such an examiner should not be as qualified as any other examiner.

5. Income Reporting

Under the plan proposed by the President in his original Family Assistance Plan and adopted by the House in April of 1970 an equitable system of determining eligibility and payment levels would have been established. The basis for welfare payments would have been the estimate the Secretary of Health, Education, and Welfare made of the income a family would have during each quarter. For future payments, this estimate could be redetermined as the Secretary became aware of changed circumstances.

My amendment will reinsert the President's original language. There will remain an obligation on the part of the welfare recipient to report changes in circumstances affecting need and eligibility in any event, thereby making H.R. 1's mandatory quarterly reports of income superfluous.

The harsh \$25, \$50 and \$100 penalty provision for failure to file income reports would also be stricken from the bill under my amendments. The provision is indiscriminate since penalties apply for failure to file even in cases where a failure to furnish information results in receipt of lower benefits than a family is entitled to.

6. Reregistration for Benefits

H.R. 1 requires recipients to reregister every two years to allow HEW to review and study the problems of the long-term poor. My amendment would place the burden on the Secretary to take the time to select these cases for study rather than on the recipients.

7. Stepparent Liability

My proposal would eliminate H.R. 1's provision which makes stepparents of FAP children liable for support payments, apparently under the assumption that the stepparents' income is available to the entire family. This will only encourage stepparents to leave home to enable the family to receive benefits. This regressive provision encourages family dissolution and in reality leaves the mother to provide for the family by herself.

HEW's regulations now require that nonavailable income of a household not be attributed to a family unless that person is liable under a State law of general applicability for the support of someone in the family. My proposal would follow the HEW regulation and eliminate the legal fiction, held unconstitutional in 1970 by the Supreme Court in *Lewis v. Martin* (397 U.S. 552), that the income of a stepfather need not support his wife's children unless he adopts them. A harsher rule will act as a disincentive to marriage and family stability. Nothing more should be done to undermine the social structure of this society.

8. Inclusion of Migrant Workers

A family is defined in H.R. 1 as two or more related persons living together in a place maintained by one as his or her home, who are U.S. residents and one of whom is a citizen or permanent resident alien. The definition "maintained as a home" is expanded and clarified under my amendment to assure that migrants and others of unfixed domicile are not excluded under a rigid interpretation of this section.

9. Coverage for Impoverished Students

Another arbitrary definition absolutely excludes any family whose head is an undergraduate or graduate student "regularly attending a college or university". This arbitrarily prevents any recipient from pursuing a higher education, even though within a brief period his or her earnings potential would rise far above dependency levels.

Denying this segment of the population assistance for a period which is certain to be of short duration serves no purpose and may prevent an individual from completing the education necessary to compete successfully in American society. The exclusion would even exclude from eligibility a family head who might be working or willing to work full-time and study part-time, at his own expense, on a scholarship, or even at a free public institution.

Current aid programs do not preclude college attendance. Under the WIN program, for example, recipients can regularly attend college under the administrative determination that this is the best "employability" plan for them. To assure that assistance is based exclusively on need, my amendment would eliminate this arbitrary exclusion.

10. Protection of Employee Rights

This amendment would protect accrued rights of State and local government employees and aid them in obtaining employment. While this amendment does not freeze every welfare worker into the new welfare system, it provides protection for the accrued rights of workers "federalized" under the Family Assistance Plan and assistance in obtaining new training and employment for those who do not continue employment under this legislation.

As the Federal Government assumes responsibility for the welfare system in America, it must be careful not to create a situation in which the administrators of the old welfare system become potential recipients under the new system. At least 90,000 public employees who presently perform the administrative functions under the current welfare system must be protected.

My proposal would provide protection of collective bargaining rights, salary levels, pension rights, seniority rights, credits for annual leave, and other terms and conditions of employment for those employees transferred to the Federal program.

Such protection has traditionally been provided by Congress, most recently in the Rail Passenger Service Act of 1970 which guaranteed employees' rights under the newly created AMTRAK Rail System. Broad protection of employees' rights and benefits was also assured in the 1964 Urban Mass Transit Act.

Inevitably, a reformed welfare system will need fewer employees

to administer it. For those employees who are not "federalized" my amendment will assure employment by the Federal or State government and pay for funds for the training necessary to carry out this purpose.

11. Elimination of State Residency Requirements

My amendments eliminate H.R. 1's residency requirements. The Supreme Court has consistently held such requirements to be unconstitutional. The Court recently reaffirmed an earlier case which found residency requirements unconstitutional restrictions on the right to travel and a violation of the Equal Protection Clause. The Supreme Court found such requirements to be "invidious distinctions" between classes of citizens which cannot be justified even for the purpose of State welfare cost savings.

From a practical standpoint such restrictions have little effect on welfare rolls or costs. A recent study in New York indicated that the vast majority of people who go on welfare do so only after several years of working at menial jobs or of living in crowded apartments of friends and relatives who have jobs. In fact, of New York State's 1.7 million public assistance recipients as of January, 1971, only 11,000 (mostly children), or less than 1% had gone on welfare after living in the State for less than a year.

I. COVERAGE FOR CHILDLESS COUPLES AND SINGLE PERSONS

A major premise of H.R. 1 is that welfare assistance should be based on need rather than membership in a particular population category. Nonetheless 1.8 million persons under 65 in families without children and 2.3 million single persons who live in poverty are not eligible under H.R. 1.

My amendment would remedy this failing, recognizing that the incidence of poverty reaches the highest levels among persons unconnected with a family unit. At least 500,000 of these people have no cash income at all. Moreover, it makes no sense to deny assistance to a couple without children and provide \$2,000 to a couple with one child. The incentive to have children under such an illogical exclusion makes H.R. 1 a Family Expansion Plan rather than a Family Assistance Plan.

Coverage for these forgotten Americans would begin in fiscal 1974 to allow the Secretary of Health, Education, and Welfare to establish the necessary administrative procedures to include them for the first time in Federal welfare programs.

This amendment would cost the Federal Government \$1 billion in its first year of operation.

K. SUMMARY COMPARISON OF RIBICOFF WELFARE AMENDMENTS WITH H.R. 1

Ribicoff Amendments

H.R. 1

1. Payment Levels

(a) No beneficiary would receive less than he or she is now receiving.

(b) Initial Federal payment level of \$3,000 for a family of four.

(c) Each year payment levels would increase until by 1976 no recipient would receive less than the poverty level adjusted annually for rises in the cost of living.

(a) No such protection.

(b) Permanent Federal payment level of \$2,400.

(c) No increase in Federal payment above \$2,400.

2. State Supplementation

(a) States whose welfare payment plus food stamp benefits exceed the income levels set by this bill would be required to make supplemental payments up to the January 1971 payment levels. This assures that the massive State welfare cutbacks of the last two years would be rescinded. The Federal Government would pay 30% of these supplemental payments.

(a) No requirement that States maintain current cash payment levels or add value of food stamps. Supplementation would be optional.

3. State Fiscal Relief

(a) Over the next five years no State would have to pay more than 90%, 75%, 50%, 25%, and 0% of its calendar 1971 public assistance costs. Thus by 1976, the welfare program would be fully federalized.

(a) States protected only against increased costs over calendar 1971 expenditures.

(b) Additional Ribicoff Amendment 820 would freeze FY 1972 and FY 1973 State welfare costs at fiscal 1971 levels, resulting in State savings of \$2 billion over the two year period. Federal Government would assume additional costs.

4. Imposed Work Incentives

(a) The working poor would be allowed to obtain \$720 plus 40% of any additional income without loss of benefits. Additionally, the Secretary would be required to carry out tests of various earnings disregards to develop an optimal work incentive.

(b) Provision of at least 300,000 public service jobs.

(c) All job referrals would have to be at the prevailing wage rate but in no case less than the Federal minimum wage.

(d) Mothers with children under age 6 would be exempt from work registration requirements and no recipient would be required to undergo work training unless suitable child care and a job following that training were available. Priorities for jobs would assure that no mother is forced to go to work against her will.

(e) \$1.5 billion would be made available for child care services under the program established by HEW pursuant to law.

(a) The working poor would be allowed to retain \$720 plus one-third of any additional income without loss of benefits.

(b) Provision of 200,000 public service jobs.

(c) Referrals to jobs could be at wages as low as three-quarters of the Federal minimum wage (\$1.20/hour).

(d) Mothers with children over age 3 would be required to register for work.

(e) \$700 million for day care.

K. SUMMARY COMPARISON OF RIBICOFF WELFARE AMENDMENTS WITH H.R. 1—Continued

5. *Eligibility and Administration*

Ribicoff Amendments

H.R. 1

- (a) Eligibility would include single individuals and childless couples.
- (b) Eligibility based on current need.
- (c) Procedural changes to assure due process, including right to counsel, notice, hearings, written decisions, equitable income reporting.
- (d) Elimination of State residency requirements.
- (e) Equitable provisions for U.S. territorial possessions.
- (f) Protection of employee rights.

- (a) No coverage for single individuals or families without children.
- (b) Bases eligibility on earnings in prior quarters which may result in denial of benefits to migrants and other seasonal workers.
- (c) Claimant's rights not adequately specified.
- (d) States allowed to retain State residency requirements.
- (e) No such provisions for U.S. territories.
- (f) No protection of employee rights.

6. Social Services and HEW

(a) The provisions of existing law regarding social services authorization would be restored, eliminating H.R. 1's ceiling on these services.

(b) The Department of Labor would be required to utilize HEW-supported programs in providing necessary services.

(a) Ceiling on social services authorizations.

(b) Possibility of Department of Labor programs parallel to HEW services.

7. Pilot Projects for OFF

The Department of HEW would set up demonstration projects of the Opportunities For Families Program which becomes effective on January 1, 1974. The demonstrations will test out the work experience and incentives of participants, the effect on families, the types of services needed for the working poor, and the administrative procedures. The OFF program would be automatically triggered unless rejected by a majority vote of both houses of Congress.

TABLE 4
IV. TOTAL FEDERAL WELFARE COSTS: FISCAL 1974—FULL YEAR BASIS
[In billions of dollars]

	Current law	H.R. 1	Ribicoff amendments	Finance Committee proposal
Family payments.....	4.8	6.0	11.3	
Wage subsidy.....				1.9
10-percent rebate.....				1.1
Residual AFDC.....				3.7
Guaranteed employment.....				4.1
Childless couples and singles.....	0	0	1.0	
Hold harmless provision.....		1.3		
Food programs.....	2.4	1.0	1.0	1.8
Child care services.....	.3	.7	1.5	.8
Child care facilities construction.....	0	.05	.1	
Support services.....	0	.1	.1	
Manpower training.....	.2	.54	1.0	.7
Public service jobs.....	0	.8	1.2	
Equal employment compliance activities.....	0	0	.01	
Administration (all programs).....	.4	1.1	1.1	1.3
Miscellaneous.....	0	0	0	
Impact of other programs.....		-.1	-.1	-.1
Total.....	8.1	11.4	18.2	15.3

¹ Figures do not show reductions as a result of 20 percent benefit increase.

TABLE 5.—COMPARISON OF MAJOR FEATURES OF WELFARE PROGRAMS FOR FAMILIES

	Current law	H.R. 1	Ribicoff amendments	Finance Committee proposal
Payment level.....	Varies by State.	\$2,400 plus incentives for State supplements.	\$3,000, and up to poverty line by 1976.	\$2,400 plus no incentive for State supplements.
Earnings disregard..	\$30 plus ½...	\$720 plus 33 percent.	\$720 plus 40 percent.	Many different formulas.
Break-even point....	Varies widely.	\$4,320	\$5,720	
Number of eligible people.	15 million....	19.3 million..	30 million....	30 million.

V. MINIMUM PRINCIPLES OF WELFARE REFORM

Over the last three years many welfare reform bills have been introduced and debated at length. No single piece of legislation is going to eliminate poverty in America. The most that an adequate welfare reform bill can do is provide short-term relief to people who live in an imperfect society which has yet to solve its basic problems of jobs, housing, education and health care. Amendment 559 would provide that relief.

It incorporates what I consider to be the minimum principles of welfare reform. Before enacting any bill into law Congress should measure it against the yardstick of the following minimum principles:

A. We must assure that no recipient receives less following welfare reform than he or she now receives. In States where payments are higher than the Federal guarantee level, States must be required to make supplemental payments up to the level at which they were paying in January of 1971 or any previous or subsequent higher level. This will rescind all of the State welfare cutbacks of recent years.

B. Benefits levels must increase automatically on an annual basis according to increases in the cost of living. Such a principle has recently been adopted for social security benefits. Eventually, benefits should provide a poverty-level income.

C. We must adopt a national welfare system with uniform rules for determining eligibility and need under Federal administration.

D. Fiscal relief for the States must be part of a welfare reform system. By assuring that State costs for welfare will not have to rise above their 1971 levels (as envisioned in Amendment 559 and H.R. 1), States will be able to plan their budgets on a rational basis.

E. Any jobs that are provided to employable welfare recipients must be at no less than the Federal minimum wage. The present \$1.60/hour is already \$700 less than the poverty level on an annual basis. Surely there is no justification for paying lower wages.

F. Adequate protections to assure that mothers aren't forced to work and leave their children against their will are mandatory.

The Ribicoff amendment achieves this goal by automatically exempting mothers with children under age 6. It further exempts mothers with children over age 6 unless adequate day care meeting the 1968 Federal Interagency Day Care Requirements is available and unless suitable jobs meeting minimum safety and health requirements and paying no less than the Federal minimum wage is available.

A final safeguard against a forced work requirement is the priority listing for job placement. Volunteers would be placed before all others and since the number of applicants for jobs has always exceeded the number of job slots, even the volunteer manpower pool would not be exhausted.

G. The method of determining eligibility and need must be based on a "current need" system. That is, welfare payments must provide for the needs of recipients at the present, notwithstanding income earned in the past. Safeguards can be built into the accounting period to assure that those with high incomes cannot take advantage of the system.

H. Administrative procedures assuring fairness, dignity and due process to the recipients must be afforded, including right to counsel, hearings meeting the standards of the Administrative Procedure Act, written decisions, quick determination of eligibility, the rights to appeal, and simplified administrative procedures easily understandable and responsive to the recipients' needs.

I. Income supplements must be provided to those who work full time to support themselves and their families, but still have a sub-poverty level income. By aiding the working poor, an incentive is built into the system assuring that it is always more profitable to work than to receive welfare.

J. Any system of public assistance must provide jobs for those willing to work—either in the private or the public sector.

Public service employment is an area in which the need for employees is overwhelming. A quick look at the condition of our cities, rivers, air and environment in general confirms this need. It has been estimated that State and local governments could use as many as 4 million additional people to provide the basic services expected of government. All such jobs must meet Federal minimum wage standards as well as health and safety criteria.

K. A social services component, including comprehensive day care meeting the 1968 Federal Interagency Day Care Requirements is also needed to provide the ancillary assistance enabling a family to move, if possible, toward full self-support.

Ultimately, we must recognize that a welfare system cannot solve the problems of poverty. Public assistance is only a short-term means of alleviating the deleterious long-term effects of a society which has yet to solve the basic problems of providing good jobs, housing, education and health care.

Over the last 3 years I have been in frequent contact with the administration to work out a compromise bill which contains the principles I consider crucial to meaningful welfare reform. As a result of these negotiations I reached agreement last spring with the Secretaries of HEW and Labor on a reform bill encompassing these principles. Unfortunately, this agreement was not accepted, thereby substantially diminishing the chances of obtaining meaningful welfare reform this year. Unless the Senate now moves to fill the leadership void created, those living in poverty in this country are doomed to more years of desperation.

II. MEDICARE AND MEDICAID

A. MEDICARE: NEEDED ADDITIONS

The Finance Committee has made a series of major changes in the Medicare programs, many of which I support. Unfortunately, more remains to be done.

1. PUBLIC DISCLOSURE UNDER MEDICARE

I am disappointed that the Committee did not accept my Medicare disclosure amendment. As the American public and Congress analyze the need for reform in this Nation's health care system, it is imperative that the merits and failings of the present system be fully known. Unfortunately, a confidentiality provision of the Social Security Act, section 1106, has placed an obstacle in the path of obtaining needed information concerning the workings of our medical system. The secrecy requirements, enacted in the late 1930's to prevent unscrupulous politicians and tradesmen from obtaining lists of Old-Age Assistance recipients for the purpose of political propagandizing and high-pressure selling are now being used beyond their original intent.

Section 1106 forbids disclosure of "any file, record, or other paper or any information" obtained by the Social Security Commissioner except as expressly allowed by him. Today, in conjunction with "Reg-

ulation No. 1", this sweeping confidentiality provision has become HEW's equivalent of the Pentagon's "classified for national security" provision.

Instead of protecting the individual Medicare patient or Social Security recipient from a possible violation of privacy, section 1106 and its regulations have been utilized to deny access to information concerning the performance of fiscal intermediaries (insurance companies) under Medicare, hospital surveys, nursing home performance, deficiencies in other types of medical facilities and the administrative relationships between hospitals, physicians and insurance.

Access has also been denied to Social Security Manuals which govern many aspects of the operation of Medicare by intermediaries with respect to claims of Medicare enrollees. Information has also been impossible to obtain on doctors' customary charges for private office visits in various localities.

Apparently Medicare officials think the public should not see the contents of the reports. It seems more likely to me that if the public saw these reports, many of which show substandard performance, they would understand all too well the implications of shoddy performance, substandard medical care and improper cost arrangements.

The taxpayer spends over \$6.3 billion a year for the Federal hospital insurance program yet the facts of its operation and the causes of ever-increasing hospital costs are buried in secrecy. The result has been that some insurance companies continue to participate in Medicare despite poor performance records as fiscal agents. Surveys of hospitals which have lost their accreditation go unnoticed. Unsafe nursing homes and other medical facilities with substandard performance records remain in operation free from public scrutiny. And hospital and medical costs go up beyond reason because the public and State officials cannot obtain adequate information on which to base cost and quality controls.

While it represents some progress, the Finance Committee substitute provision fails to eliminate Section 1106. The Committee would not make inspection reports on hospitals and nursing homes available to the public. Rather it would simply permit the Social Security Administration to produce a digest or condensation of the basic report, which would not be disclosed. Perhaps 40 of 400 deficiency items in the nursing home inspection reports would be disclosed or digested and SSA would pick the items. Survey reports on hospitals made by the Joint Commission on the Accreditation of Hospitals would not be made publicly available, nor would reports already in existence at the time of enactment of this legislation. In effect, reports made before the effective date of H.R. 1 would be kept secret.

My amendment, Amendment 825, would clarify the intent of Congress, specifying that the grant of secrecy authority applies only to the privacy of specific beneficiaries and taxpayers. Further, it prohibits HEW from hiding factual information on institutions, carriers, and States under Medicare and Medicaid.

Amendment 825 has received widespread support, including that of Senator Frank Moss, Chairman of the Aging Committee's Long-Term Care Subcommittee, the Health Security Action Council, the National Consumers League, the National Health and Environmental Law Pro-

gram, diverse local organizations, as well as distinguished writers in the health care field.

2. PILOT PROJECTS FOR CARE OF THE ELDERLY

The Finance Committee did not accept my proposal to establish pilot programs designed to generate alternatives to long-term institutionalized nursing home care.

We must begin to look at our entire nursing home system in light of increasing evidence that the care provided for our elderly citizens is inadequate, demeaning to human dignity and a waste of tax dollars.

Nursing homes as they are operated today are a self-perpetuating system that assures that the elderly will have a chronic need for chronic health care. Our extended care institutions all too often reduce our elderly citizens to a state of permanent dependence on the institution, rather than providing varying levels and types of care and services that would encourage the elderly to remain a part of their community.

At least 15 to 20 percent of those elderly citizens presently institutionalized are absolutely misplaced according to the Levinson Gerontological Policy Institute of Brandeis University. In Massachusetts, for example, where intensive studies of nursing-home disability evaluations have been made, it was found that only 37 percent of the nursing home residents in the State required full-time skilled nursing care. Fourteen percent needed no institutional care whatsoever for medical reasons. Another 26 percent required minimal "supervised living", and 23 percent needed limited or periodic nursing care that might, for some, be provided on a home visit basis.

Approximately \$2 billion is expended annually for nursing home care, one-fourth to one-half of which is now spent for patients who do not, medically, need such care. A more flexible use of funds now narrowly channeled into traditional nursing home settings would encourage the development of more imaginative and innovative forms of care for the elderly.

My proposal authorizes a series of pilot projects to explore new methods of providing care for the elderly. The purpose of these demonstration programs would be to generate alternatives to long-term, institutionalized nursing home care. Such programs would include: maintenance and care services provided in noninstitutional, neighborhood settings; increased use of home health and maintenance care; continuing care at various stages of illness through a coordinated program utilizing acute care hospital facilities, extended care facilities, "day" hospital services, and home care; and on ongoing community responsibility and involvement in such programs.

These pilot projects would provide field testing of differing solutions in varied demographic and health care delivery areas. Other issues to be explored in field tests would include the administrative issues involved in setting up innovative personal care organizations, definition of the optimal population to be covered, testing of alternate quality control measures, analysis of manpower alternatives, and measurement of cost levels.

The costs of providing adequate care for the elderly are rising dramatically. We cannot continue to waste and misallocate the limited

resources we have to devote to this problem. More effective programs must be developed. Working with such programs in action is the only way this can be done.

3. HOME HEALTH SERVICES

The committee did not accept my amendment to make the home health services program more flexible by eliminating the three-day hospital stay requirement as a condition for receiving home health services.

Under existing law a Medicare beneficiary is not entitled to home health services until he has been hospitalized for a minimum of three days. Thus, a physician is forced to hospitalize his patient to insure Medicare coverage even though the optimum health care services might be provided in the home through a home health agency at a significant savings.

The HEW Medicare advisory committee, the Health Insurance Benefits Advisory Committee, has recommended that the hospitalization requirement as an eligibility criterion for home health services be eliminated. My amendment would implement that recommendation.

Our present Medicare law requires hospitals and extended care facilities to carry out utilization review activities in the interest of effective use of scarce resources and improvements in levels of care. My proposals would extend this requirement to home health agencies as well.

Home health services also need to be coordinated more effectively. They are now administered through three major organizational components of the Department of Health, Education, and Welfare—the Social Security Administration, the Social and Rehabilitation Services and the Health Services and Mental Health Administration. A home health agency at the local level is frequently confronted with three conflicting sets of ground rules. To improve coordination, an advisory committee on home health services should be appointed to assist the Assistant Secretary for Health and Scientific Affairs in administering home health services provided under Medicare, Medicaid and the Maternal and Child Health Program.

B. MEDICARE: AMENDMENTS ACCEPTED

The Committee has adopted a number of proposals I introduced which will improve and expand the Medicare program.

1. INSPECTOR GENERAL

I am pleased that the Committee accepted my proposal to create an Office of Inspector General for Health Administration.

No independent reviewing mechanism is presently charged with specific responsibility for ongoing and continuing review of Medicare and Medicaid in terms of their efficiency and effectiveness. Our hearings on the operations of these programs documented the need for such review by disclosing inefficiencies, wasteful expenditures and non-compliance with legal requirements.

While the Comptroller General and the Department of Health,

Education, and Welfare's Audit Agency have done some valuable and helpful work in reviewing Medicare and Medicaid operations, a pronounced need exists for vigorous day-to-day and month-to-month monitoring of these programs, which now cost \$15 billion annually.

This amendment would establish an Office of Inspector General for Health Administration within the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the Social Security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the law and Congressional intent.

The Inspector General would be provided with authority sufficient to assure that Medicare and Medicaid function as Congress intends. The responsibilities and role envisaged for the Inspector General for Health Administration are essentially patterned after the successful approach employed in the Agency for International Development and the investigative and reporting responsibilities with respect to Congressional requests required of the U.S. Tariff Commission.

The Inspector General is to make recommendations for correction of deficiencies or for improving the organization, plans, procedures, or administration of the health care programs. He is also to provide the Congressional Committees on Finance and Ways and Means with any material or information requested.

In carrying out his duties, the Inspector General will have access to all Federal records, reports and information relating to health care programs. He will also have authority to suspend any regulation, practice, or procedure employed in the administration of a program if he determines that the suspension will promote efficiency and economy in the administration of the program, or that the regulation, practice, or procedure involved is contrary to or does not carry out the objectives and purposes of applicable provisions of law. In order to enable him to carry out his duties, the Inspector General could devise uniform reporting standards which would allow him to make adequate comparisons of provider and intermediary performance.

I am convinced that this new office will make a major and badly needed contribution to the efficiency of our massive Federal health programs.

2. NURSING HOMES

The Senate Finance Committee adopted most of the provisions of my amendment—No. 958—to improve the conditions in nursing homes.

Specifically the provisions of my amendment which were accepted were:

- (1) The retention of existing requirements that nursing homes provide social services to patients (H.R. 1, section 265 deleted such a requirement)
- (2) The requirement that at least one full-time registered professional nurse be employed on every nursing home staff (H.R. 1, section 267, deleted this requirement)
- (3) The requirement that State licensure examinations be taken by nursing home administrators (H.R. 1, section 269, deleted this requirement)

(4) The unification of Medicare and Medicaid standards for nursing homes at the higher of present standards.

The adoption of these standards will enhance the quality of life in homes for the elderly.

3. HOSPITAL ACCREDITATION UNDER MEDICARE

The Finance Committee also adopted my amendment—No. 973—which would require the Federal Government to review the process by which the private Joint Commission on Accreditation of Hospitals (JCAH) accredits hospitals for participation in the Medicare program. This proposal would also require the Federal Government to develop new accreditation guidelines where none now exist.

Under the present law, the Secretary of Health, Education, and Welfare is authorized to promulgate regulations necessary to insure the health and safety of persons receiving care in participating hospitals but he may not promulgate standards higher than those established by JCAH. In addition, any hospital which has received accreditation by JCAH is deemed to meet any conditions which the Secretary might promulgate. These are improper delegations of authority to a private, interested organization.

Amendment 973 specifically would give the Secretary the authority to promulgate conditions of participation which are higher than those established by JCAH if the Secretary determines that JCAH's requirements are inadequate. Secondly, the amendment would authorize the Secretary to inspect hospitals which are JCAH-accredited on a sample basis and when he has reason to believe they fail to meet JCAH standards and to make a determination whether such hospitals met the standards imposed by JCAH.

While this amendment is a first step toward making hospitals more accountable to the public, more remains to be done. Standards promulgated by the Secretary should be applied uniformly to all hospitals. Procedures should also be adopted to assure that there is a strong consumer participation in the accreditation process. Regulations promulgated by the Secretary should provide that consumers of a hospital's services be permitted to request an adjudicatory proceeding before a representative of the Secretary at which evidence relative to the hospital's compliance with JCAH and other applicable standards would be introduced. At present the accreditation process is limited to a JCAH site inspector with input only from hospital administrators and staff.

4. GAO AMENDMENT

The Finance Committee adopted my amendment—No. 954—which would provide authorization for the General Accounting Office to analyze Social Security legislation, review and evaluate ongoing programs, temporarily assign GAO employees to Congressional Committee to assist them in their work, and periodically audit Federal research, development and procurement programs. The amendment would also require GAO to approve any contracts for evaluation of Social Security programs if an expenditure of more than \$25,000 for the study is involved. The Comptroller General's approval would be conditioned on his determination that:

(a) The conduct of such study or evaluation of such program is justified;

(b) The department or agency cannot effectively conduct the study or evaluation through utilization of regular full-time employees; and

(c) The study or evaluation will not be a duplication of any study or evaluation which is being conducted, or will be conducted within the next twelve months, by the GAO.

The purpose of this amendment is two-fold. First, it reduces Congressional reliance on the Executive Branch for information concerning legislation. Too often statistical data is received from the Executive Branch which is erroneous, self-serving or untimely. This provision would give Congress its own source of data.

Second, GAO approval over "evaluation" contracts will save money by eliminating the often duplicative and useless evaluative studies being carried out of Social Security programs. While evaluations are necessary to determine the effectiveness of programs, such situations as 44 evaluation of Head Start do not contribute to the legislative process. This amendment will coordinate the evaluation process.

5. LIMITATIONS ON COSTS TO BENEFICIARIES

The Finance Committee also adopted a series of amendments to the Medicare program I proposed to limit the cost burden on the aged beneficiaries of this program.

As the Medicare program has grown to accommodate the health needs of the aged, costs have increased far beyond projected estimates. This is not the fault of the senior citizen. Nonetheless, we are now cutting back on costs by putting the financial burden back on the individual patient—the one least able to bear the burden. My amendment would halt proposed increases in deductibles under Medicare.

Under Medicare, a beneficiary is presently required to pay the initial \$50 of covered expenses during a year plus at least 20% of the balance. H.R. 1 would increase that deductible to \$60. My proposal, accepted by the Committee, would restore the \$50 deductible level.

Another rising deductible is that for hospitals. The Social Security Act requires the Secretary of HEW to determine and promulgate between July 1 and October 1 the inpatient hospital deductible applicable to any spell of illness.

In October of 1971, the Secretary raised the deductible from \$60 to \$80, an action expected to adversely affect about four million people for whom the average stay in a hospital is 12.2 days, and costs about \$800. My amendment freezes the inpatient hospital deductible at \$60 and freezes the \$15 copayment for the 61st through 90th days of hospitalization at the \$15 level. The freeze on deductibles and copayments which I am proposing would apply to treatment in an extended care facility as well.

6. MEDICARE FOR THE DISABLED

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians'

services as do the nondisabled population. In addition, the disabled are often unable to obtain private health insurance.

Effective July 1, 1973, a Social Security disability beneficiary would be covered under Medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled widows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.5 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is \$1.5 billion for hospital insurance and \$350 million for supplementary medical coverage.

C. MEDICAID

The purpose of the Medicaid program is to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary medical care and to move toward the provision of comprehensive medical services to program eligibles by 1977. The Committee bill includes several provisions which dilute rather than strengthen the impact of the original law and which I will oppose on the floor.

The Committee has included two provisions (Sections 230 and 231) which would seriously impede the program's ability to provide needed medical assistance to the eligible poor:

Section 230: Title XIX (Section 1903(e)) requires that each State demonstrate that it is making efforts in the direction of broadening the scope of services in its Medicaid program and liberalizing eligibility requirements with a view toward furnishing comprehensive care and services to all eligible individuals by July 1, 1977. The Committee proposes that we renege on our commitment to the Nation's poor by eliminating the requirement that States move toward more comprehensive Medicaid programs. Those States whose services are inadequate or who do not cover the medically needy will have no incentive to broaden the scope of their services.

Section 231: Title XIX (Section 1902(d)) permits States to reduce the amount, duration, and scope of Medicaid services, but prohibits them from reducing their aggregate fiscal expenditures from one year to the next. The Committee proposes to repeal this minimal requirement. Passage of the Committee provision would encourage States to make drastic cutbacks in the scope of services offered thereby depriving the poor of needed medical care.

The Committee has substantially improved on the efforts of the House to eliminate the Medicaid "notch". Under the Committee bill, working families will have a chance to enroll in Medicaid and will be eligible for benefits for one year after receiving earnings. Families who wish to continue eligibility after this period will be required to pay a premium equal to 20 percent of income in excess of \$2,400 annually. This premium assessment proposed in Section 209 of the Committee bill is excessive and should be substantially reduced.

The Committee has also included several amendments which are directed toward improving the standards for skilled nursing homes and

conforming standards for extended care facilities under Title XVIII and skilled nursing homes under Title XIX. The Committee, however, includes two provisions which would result in the weakening of standards:

Section —: The Committee has added a provision which would authorize the Secretary to make a determination, based primarily on State agency evaluation, on whether a facility qualifies to participate as a "skilled nursing facility". Under current Medicare policy homes are permitted to remain in substantial compliance indefinitely while under the Medicaid law homes not meeting the standards are granted only two six-month provider agreements. Certification under the Committee provision should in no case result in the weakening of requirements.

The Committee has also included two provisions which discourage the provision of needed preventive care:

Section 208: The Committee would require States to impose monthly premium charges on their medically indigent and would permit the imposition of copayments and deductibles on "patient initiated" elective services for the same population group. Implementation of this provision could result in an administrative nightmare. More importantly, however, to the extent that the medically indigent are discouraged from receiving necessary preventive care, they will defer entrance into the system until their illness becomes more severe and its cure far more costly.

Section 207: The Committee would remove the positive incentive contained in the House bill (Section 207(a)(1)) for the States to utilize health maintenance organizations. Such organizations have proven that they can deliver services more efficiently and economically by emphasizing preventive care. Their use should therefore be given further encouragement.

The Committee has indicated its desire to improve the operating efficiency and effectiveness of the Medicaid program. However, it has included a provision which would counter such improvement:

Section 235: The Committee deleted the provision contained in the House bill which would provide 90 percent Federal matching for the design, development and installation of claims processing and information retrieval systems and 75 percent Federal matching for the operations of such systems. States who do not have effective claims administration or properly designed information storage and retrieval systems do not have the financial and technical resources to develop them. Deletion of the increased matching provision will mitigate against the possibility of States correcting their deficiencies.

XVII. ADDITIONAL VIEWS OF MR. BYRD, JR., OF VA.

(1283)

XVII. ADDITIONAL VIEWS OF MR. BYRD, JR., OF VIRGINIA

The Committee bill represents three years of work. It is a complete rewrite of the welfare portions of H.R. 1, which twice has passed the House of Representatives.

H.R. 1 was described best by its chief advocate, HEW Secretary Elliott Richardson, when in his formal testimony to the Senate Committee on Finance he termed it "revolutionary and expensive."

I could not support H.R. 1 as passed by the House of Representatives and as endorsed by the Nixon Administration because:

- (1) it writes into law the principle of a guaranteed annual income;
- (2) it is lacking in work incentives;
- (3) it would double the number of people on welfare;
- (4) it would require 80,000 additional Federal employees to administer; and
- (5) it would add \$5 billion to the cost of welfare.

The Committee proposal is a substantial improvement over H.R. 1. It would guarantee jobs rather than income. Its concept is workfare rather than welfare. Its purpose is to get people off of welfare and into jobs.

I approve the concept of the Committee proposal. The Committee, in my judgment, has rendered the American people a great service by refusing to approve H.R. 1. Much of the credit for this must go to the Committee Chairman, Senator Long, who has insisted from the beginning that an appropriate workfare bill could be developed.

My chief reservation concerns the cost. It is not more expensive than H.R. 1 and may be less costly. But with the Federal Government running a three year Federal funds deficit of approximately \$100 billion I want to reserve judgment as to how I shall vote on this measure when it comes before the Senate. It will depend somewhat on how it might be amended on the floor of the Senate.

I have voted to report the Committee bill to the Senate, but I reserve judgment on how I shall vote on final passage.

